# Nursing and Midwifery Council
# Fitness to Practise Committee

### Substantive Hearing
### Wednesday-Wednesday, 25 March- 2 April 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

| | | |
|---|---|---|
| **Name of Registrant:** | Maria Charito Estrella Poblete | |
| **NMC PIN** | 03G0273O | |
| **Part(s) of the register:** | Sub part 1 Registered Nurse - Adult | |
| **Relevant Location:** | Ards and North Down Borough Council | |
| **Type of case:** | Misconduct | |
| **Panel members:** | Derek McFaull<br>Melanie Lumbers<br>Isobel Leaviss | (Chair – Lay member)<br>(Registrant member)<br>(Lay member) |
| **Legal Assessor:** | Nicholas Baldock | |
| **Hearings Coordinator:** | Peaches Osibamowo | |
| **Nursing and Midwifery Council:** | Represented by Rosie Welsh, Case Presenter | |
| **Maria Charito Estrella Poblete:** | Not Present and unrepresented | |
| **Facts proved:** | Charges 1, 2, 3 and 5 | |
| **Facts not proved:** | Charges 4 | |
| **Fitness to practise:** | **Impaired** | |
| **Sanction:** | **Conditions of Practice Order (12 months)** | |
| **Interim order:** | **Interim conditions of practice order (18 months)** | |

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Ms Poblete was not in attendance and that the Notice of Hearing letter had been sent to Ms Poblete's registered email address by secure email on 20 February 2025 which satisfies the notice period requirements.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Ms Poblete's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Poblete 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 Ms Poblete**

The panel next considered whether it should proceed in the absence of Ms Poblete. It had regard to Rule 21 and heard the submissions of Ms Welsh who invited the panel to continue in the absence of Ms Poblete. She submitted that Ms Poblete had voluntarily absented herself and after not responding to emails from the NMC regarding the hearing, she answered a phone call from the NMC on 26 March 2025 and stated that she would not be present at the hearing and *'would like the panel to proceed with the hearing in her absence'*.

As such, Ms Welsh submitted that there was no reason to believe that an adjournment would secure Ms Poblete's attendance on some future occasion.

The panel has decided to proceed in the absence of Ms Poblete. In reaching this decision, the panel has considered the submissions of Ms Welsh, the documented telephone call with Ms Poblete on the morning of 26 March 2025 prior to the hearing commencing, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision in *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 Ms Poblete;
- Until the telephone conversation on 26 March 2025, Ms Poblete had not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- Ms Poblete informed the NMC that she would not be attending the hearing via a telephone conversation on 26 March 2025;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A witness is due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- 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.

Inevitably, there is some disadvantage to Ms Poblete in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her via email, she has given no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her

own behalf. However, in the panel's judgement, this can be mitigated. The panel can take account of the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can raise questions and explore any inconsistencies in the evidence which it identifies. Furthermore, the disadvantage is the consequence of Ms Poblete'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 Ms Poblete. The panel will draw no adverse inference from Ms Poblete's absence in its findings of fact.

**Decision and reasons on application to amend the charge**

The panel heard an application made by Ms Welsh, on behalf of the NMC, to amend the wording of charges 1,2,3,4 and 5.

The proposed amendments were to clarify that the alleged omissions related to part of Ms Poblete's job role as Deputy Sister. It was submitted by Ms Welsh that the proposed amendment would provide clarity and more accurately reflect the evidence.

> "That you, a registered nurse, whilst working at ~~as the Deputy Sister of~~ [PRIVATE], in relation to Resident A ~~failed to~~:
>
> 1. **Did not** conduct appropriate reviews and/or ensure that ongoing assessments were undertaken following documentation of a sacral wound in May 2022, **as was your responsibility as Deputy Sister.**
> 2. **Did not** ensure that between 18 May 2022 and 1 October 2022 their wound assessment and/or care plan paperwork was updated, **as was your responsibility as Deputy Sister.**

3. **Did not** ensure that a Braden score was completed in July and/or August and/or September 2022, **as was your responsibility as Deputy Sister.**
4. **Did not** ensure that the MUST score was completed between 19 June 2022 and 1 October 2022, **as was your responsibility as Deputy Sister.**
5. Prior to 2 October 2022, did not appropriately escalate and/or seek advice regarding their pressure **ulcers** ~~sore~~, **as was your responsibility as Deputy Sister.**

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

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

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Ms Poblete and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy, and this did not change the substance of the charges.

**Details of charge**

*"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*

1. *Did not conduct appropriate reviews and/or ensure that ongoing assessments were undertaken following documentation of a sacral wound in May 2022, as was your responsibility as Deputy Sister.*

2. *Did not ensure that between 18 May 2022 and 1 October 2022 their wound assessment and/or care plan paperwork was updated, as was your responsibility as Deputy Sister.*

3. *Did not ensure that a Braden score was completed in July and/or August and/or September 2022, as was your responsibility as Deputy Sister.*

4. *Did not ensure that the MUST score was completed between 19 June 2022 and 1 October 2022, as was your responsibility as Deputy Sister.*

5. *Prior to 2 October 2022, did not appropriately escalate and/or seek advice regarding their pressure ulcers, as was your responsibility as Deputy Sister.*

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

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

At the outset of the hearing, Ms Welsh made a request that this case be held partly in private on the basis that proper exploration of Ms Poblete's case involves consideration of a hearsay application regarding the evidence for Witness 2 [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel accepted the advice of the legal assessor.

The panel determined to allow the application to go into private session, in part, in connection with evidence from Witness 2 in order to protect the privacy of this witness when considering the hearsay application.

**Decision and reasons on the application to admit written statement of Witness 2**

The panel heard an application made by Ms Welsh under Rule 31 to allow the hearsay testimony of Witness 2 into evidence.

[PRIVATE]

Ms Welsh submitted that Witness 2's evidence is relevant to charges 1,3 and 4 and given that the witness was directly involved in Resident A's care having been appointed as the clinical nurse facilitator (CNF) in October 2022, it is relevant evidence.

Ms Welsh submitted that that panel should consider the test as set out in Thorneycroft v NMC [2014] EWHC 1565 and she submitted that the panel must balance the interests of both Ms Poblete and the NMC when considering the factors.

Ms Welsh submitted that the NMC had acted with fairness to Ms Poblete by emailing her on 3 March 2025 to notify her of their intention to make a hearsay application, with the statement attached. Although Ms Poblete did not respond to this email, it shows that she has been given the opportunity to challenge the reliability of the statement, if she considered it prejudicial or fraudulent. Ms Poblete made the decision not to respond or attend this hearing. On this basis Ms Welsh advanced the argument that there was no lack of fairness to Ms Poblete in allowing Witness 2's written statement into evidence.

Ms Welsh submitted that Witness 2's written statement is not the sole or decisive evidence and can be tested against contemporaneous documents and Witness 1's live evidence. In conclusion, Ms Welsh submitted that it is fair to Ms Poblete and the NMC for Witness 2's written statement and exhibits to be admitted for the panel to consider.

The panel gave the application in regard to Witness 2's written statement serious consideration. The panel noted that Witness 2's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and was signed by them.

The panel considered whether Ms Poblete would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 2 to allowing hearsay testimony into evidence.

The panel considered that as Ms Poblete had been provided with a copy of Witness 2's statement and, as the panel had already determined that Ms Poblete had chosen voluntarily to absent herself from these proceedings, she would not be in a position to

cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel made reference to and applied the guidance in *Thorneycroft v NMC [2014] EWHC 1565* and highlighted the principles of relevance and fairness, noting that fairness applies to both Ms Poblete and the NMC.

The panel concluded that Witness 2's statement is relevant to the regulatory concerns because she was a Registered Nurse directly involved in the care of Resident A albeit post the allegations.

The panel found that the written statement was not the sole or decisive evidence as there is another witness who was employed at the home and there is contemporaneous evidence in support of the case.

The panel found that there was no evidence to suggest that Witness 2 had any reason to fabricate the contents of their statement. The panel noted that the statement was sent to Ms Poblete and she has not responded or raised any objections to the content of the statement or indicated that the witness has fabricated the substance of their statement.

The panel considered Witness 2's reason for not attending the hearing. [PRIVATE].

The panel considered fairness to all parties and noted that it is in the public interest in the issues being explored fully and ensuring the judicious progression of the case, which supported the admission of this evidence into the proceedings. As Ms Poblete had been notified of the hearsay application and provided with the statement prior to the hearing, the panel identified a degree of unfairness to Ms Poblete but found that she had had the opportunity to view the statement and make submissions.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Witness 2 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

**Background**

The charges arose whilst Ms Poblete was employed as a Registered Nurse at [PRIVATE] (the Home). On 10 January 2023 the NMC received a referral from the Manager of [PRIVATE], raising concerns about Ms Poblete, who had been employed as a Deputy Sister, and had worked at the home for twelve years.

The panel heard that the Home is a two floor residential nursing home for elderly frail patients and adults with physical disabilities. At the time of the concerns the home was not at full capacity (maximum capacity – 32 beds) and it was fully staffed. Ms Poblete worked day shifts on the first floor (32 beds) as the Deputy Sister.

It was reported on 2 October 2022 that Resident A, who nursing staff confirm had a history of moisture associated skin damage, had developed two Grade 2 pressure ulcers, one on each buttock. On investigation it was identified that the last care plan regarding skin damage to the buttocks was dated 3 May 2022 (care plan 7), and moisture associated skin damage for both buttocks was documented at this time with a detailed plan of care provided. There was no further documentation from Registered Nurses regarding a plan of care for the sacral wounds until October 2022.

Entries were recorded on the daily repositioning charts in relation to concerns that Resident A was suffering from sacral buttock wounds.

Ms Poblete was one of the Registered Nurses responsible for caring for this Resident A during the relevant time period. It is alleged that as Deputy Sister she also had oversight responsibilities for all nursing and care on this floor.

**Decision and reasons on facts**

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Welsh on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Ms Poblete.

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

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

- Witness 1: Registered Nurse and Manager of the Home from May 2022.

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

The panel heard evidence from Witness 1 that she was a Registered Nurse and became the manager of the home in May 2022 with ultimate responsibility *'from the front door to the back door'.* In her evidence she said *'I am responsible for everything in the home. This includes oversight of staff and residents; care provision; catering; and, governance.'* She explained that the *'failing'* home had previously been run by Four Seasons Health Care, with this responsibility being transferred to [PRIVATE] during the period of the allegations.

The panel, before considering the charges directly, determined the following in respect to what was alleged in the charges and found that Ms Poblete had overall responsibility for the first floor as the Deputy Sister.

In her resignation letter she describes herself as a Deputy Sister, and this is the role listed for her on the staff rota and payroll documents. There is also oral and written evidence from Witness 1 which notes that Ms Poblete was the Deputy Sister and had overall responsibility for the first floor of the home.

The panel went on to consider Ms Poblete's role as a Deputy Sister. The panel accepted the evidence of Witness 1 with regard to Ms Poblete's roles and responsibilities. The panel noted that the job description within the evidence bundle is undated and has not been signed by Ms Poblete, and also emanates from the new home management company. The panel, therefore, paid little regard to this document. However, from the evidence presented the panel concluded that Ms Poblete's role included basic nursing skills that any Registered Nurse should be able of completing along with enhanced responsibilities for oversight of the first floor and to ensure that the tasks outlined in the allegations, were undertaken, competed and documented accordingly. Whilst these tasks may not have been required to be undertaken by her, it found that it was her responsibility, as the Deputy Sister to ensure that the tasks were undertaken, completed and documented to the requisite standard.

The panel heard evidence that the deputy manager was in charge of the ground floor of the home whilst Ms Poblete, as the Deputy Sister, was in charge of the first floor of the home. This is reaffirmed by Witness 1's statement that indicated that Ms Poblete was responsible for collating the management reports for the first floor.

The panel noted the lack of complete records in this case, however it accepted the evidence of Witness 1 that Ms Poblete had been employed in the home as the Deputy Sister throughout the relevant period and had not undertaken any substantial periods of leave.

Therefore, the panel found that Ms Poblete had oversight and responsibility for tasks outlined in the charges, she had oversight of the care for all residents on the first floor and to ensure that staff had completed all duties assigned to them.

The panel noted that it had no evidence or submissions from Ms Poblete in respect of the allegations made against her.

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

**Charge 1**

> *"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*
>
> *Did not conduct appropriate reviews and/or ensure that ongoing assessments were undertaken following documentation of a sacral wound in May 2022, as was your responsibility as Deputy Sister."*

**This charge is found proved.**

In reaching its decision the panel took into account contemporaneous documents, such as a written statement from Witness 2 which refers to damage found on Resident A's sacrum/buttocks, care plan 7, the initial wound assessment and the care plan evaluation sheet.

The panel noted that the care plan evaluation sheet shows that on the 5, 7, 9, 11, 13 and 15 May 2022 there are entries in respect of the sacral wound. However, there is no evidence of further entries in this document until 2 October 2022, at which stage treatment is documented as being undertaken on sacral wounds.

From the written and oral evidence from Witness 1 the panel found that there was no ongoing assessment of the wound between 18 May and 1 October 2022. The panel did not find evidence of a closing assessment to state that the wound had healed, nor any ongoing assessments. Given that the entries contained in the repositioning charts show ongoing sacral issues, specifically on four occasions on 12, 15, 18 and 23 July 2022, it expected that would be a review and ongoing assessment within those findings and this has not been documented or presented to the panel. The panel would have expected to see evidence of ongoing assessments of the wound given the finding of a severe sacral wound within the repositioning chart. As the Deputy Sister Ms Poblete should have been aware of the entries in the repositioning charts and ensured appropriate reviews and ongoing assessments were being undertaken, and acted accordingly.

The panel noted that in early September 2022 fellow nurses documented Resident A's sacral wounds on two occasions. However, again there was no ongoing assessment by any staff member, nor any documented review of the wounds. As Deputy Sister, as previously outlined, it was Ms Poblete's responsibility to conduct the assessments herself or to ensure that a member of staff had done so.

The panel therefore determined that, on the balance of probabilities, charge 1 is found proved.

**Charge 2**

> *"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*
>
> *Did not ensure that between 18 May 2022 and 1 October 2022 their wound assessment and/or care plan paperwork was updated, as was your responsibility as Deputy Sister."*

**This charge is found proved.**

In reaching its decision the panel took into account contemporaneous documentation and the evidence before it, in particular, Care Plan 7, the ongoing wound assessment form, the care plan evaluation sheet and the repositioning charts.

The panel found that the initial wound assessment was documented on 3 May 2022 and the last entry in care plan 7 and the care plan evaluation sheet was on 15 May 2022. There were no further entries on these documents after this point. However, during this period the daily repositioning chart documents wounds on Resident A's buttocks and included entries of 'bottom bleeding' during July 2022. On 6 September 2022 'breaks on bottom' were recorded and on 24 September 2022 and a nurse noted '2 breaks' on the bottom in the daily progress sheets. Witness 1 told the panel that these entries in the repositioning charts and progress sheets should have led to further updates of the care plan paperwork and wound assessments.

The repositioning charts contain a number of entries, particularly during July and September, which reveals that members of the health care staff discovered 'breaks on the bottom', bleeding and two sacral wounds.

In light of this, the panel found that in her role as Deputy Sister, Ms Poblete should have carried out the wound assessments and updated both the wound assessments and care plans, or she should have ensured that they were done by another member of staff. The panel had evidence that these tasks were not completed.

The panel therefore determined that, on the balance of probabilities, charge 2 is found proved.

**Charge 3**

> *"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*

*Did not ensure that a Braden score was completed in July and/or August and/or September 2022, as was your responsibility as Deputy Sister."*

**This charge is found proved.**

In reaching its decision, the panel took into account the contemporaneous documentation of the Braden score form for Resident A and oral evidence from Witness 1 that this score should have been completed at least monthly. The panel noted the Braden score form contained entries in November 2021, December 2021, January 2022, February 2022, March 2022, May 2022 and 18 June 2022. The next entry was 2 October 2022. This is a clear break in the record between 18 June and 2 October 2022.

Witness 1 stated that it was particularly important that this score should have been undertaken and recorded on at least a monthly basis, given the history of Resident A and their vulnerabilities.

The panel established that the Braden score was not completed as per policy. As the Deputy Sister for the first floor where Resident A was a long term resident, it was Ms Poblete's responsibility to complete the Braden score, or ensure that another member of staff had done so. The panel found that this duty had not been discharged.

The panel therefore determined that, on the balance of probabilities, charge 3 is found proved.

**Charge 4**

*"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*

*Did not ensure that the MUST score was completed between 19 June 2022 and 1 October 2022, as was your responsibility as Deputy Sister."*

**This charge is NOT found proved.**

In reaching this decision the panel took into account the hearsay evidence from Witness 2.

The panel acknowledged that Witness 2's written evidence stated that the MUST score was completed on 18 June 2022 and that this was not recorded again until 2 October 2022. The panel recognised that this was hearsay evidence that could not be cross examined. However, it also has sight of contemporaneous evidence from the tissue viability wound assessment/ review form within Witness 1's documentary evidence, in which a MUST score was recorded on 30 August 2022. This document was co-signed by Ms Poblete. This reveals a clear contradiction between this contemporaneous documentary evidence and the witnesses written statement. Due to this clear conflict within the evidence provided by Witness 2, and no other evidence being presented by the NMC on this matter, the panel was not satisfied that the NMC had discharged the burden on it of proving this charge to the required standard.

The panel therefore determined, that on the balance of probabilities, charge 4 is found not proved.

**Charge 5**

> *"That you, a registered nurse, whilst working at [PRIVATE], in relation to Resident A:*
>
> *Prior to 2 October 2022, did not appropriately escalate and/or seek advice regarding their pressure ulcers, as was your responsibility as Deputy Sister."*

**This charge is found proved.**

In reaching its decision the panel took into account the Trust Guidelines for Referrals to Clinical Nurse Facilitator for Tissue Viability Support (TVN), the orally affirmed evidence from Witness 1, Resident A's patient records and the staff rota.

The panel considered the evidence before it and accepted that the pressure ulcers documented on 2 October 2022 was considered a serious wound as it was escalated to Witness 1 whilst they were on annual leave. The panel was also provided with a picture of the wound and contemporaneous documents containing detailed assessments. It is clear from the evidence that the wound was escalated to Witness 1 and that this instigated immediate action including a range of treatments and subsequent referrals to external specialists. The concern was also reported to a safeguarding team.

The panel also noted the TVN referral guidelines which clearly outlines that a referral should be made to tissue viability support if the wounds were not responding to appropriate treatment after four weeks of appropriate treatment. The panel accepted that Ms Poblete should have been aware of these guidelines.

The evidence before the panel indicated that prior to the discovery of the wound on 2 October 2022, it should have been clear to Ms Poblete that the wound required escalation as the sacral wounds were described by Witness 1 as 'the most concerning as they should have been reported and treated'. The witness told the panel that in her professional opinion 'the wounds had been present for a considerable period of time and they were not acute' and at the very least should have been escalated to senior staff within the home, prior to such deterioration.

The panel accepted that entries in Resident A's patient records alone should have sparked an escalation of the concerns. The panel noted that by 2 October 2022 there is no evidence of a referral to either senior members of staff or the tissue viability nurse.

The panel also had sight of the staff rota and acknowledged that Ms Poblete was working 3-5 days per week in September so should have been aware of and ensured the escalation of this concern regarding Resident A, especially given that the repositioning chart documents issues with wounds in May, July and September.

The panel found that as Deputy Sister it was Ms Poblete's responsibility to ensure that she or another member of staff escalated the concerns or sought advice on the wounds clearly documented within the sacral area.

In light of this the panel therefore determined, on the balance of probabilities, charge 5 is found proved.

**Misconduct and Impairment**

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Poblete'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, Ms Poblete's fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect,*

*involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Welsh invited the panel to take the view that the facts found proved were significant failings for safe and effective care and amounts to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Welsh identified the specific standards of the Code that she submitted Ms Poblete had breached, namely sections 1.2, 1.4, 3.1, 8.4 and 10.1.

Ms Welsh submitted that Ms Poblete did not ensure that Resident A received fundamental care, she did not practice safely and she did not ensure that required record keeping was undertaken. This was ultimately her responsibility as Deputy Sister on the first floor of the Home.

Ms Welsh submitted that there was actual harm to Resident A and there was potential risk of further harm if they developed an infection. Ms Welsh submitted that protecting patients from harm is at the heart of what nurses do, and Ms Poblete's neglect of this duty must be addressed.

Ms Welsh made reference to the NMC Guidance FTP2A and FTP3B on misconduct and the case of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311. Ms Welsh submitted that it was a matter for the panel to consider if there is serious misconduct in this case, and invited the panel to find that, on the basis of facts found proved, Ms Poblete's conduct breached fundamental tenets of the profession and amounts to misconduct.

**Submissions on impairment**

Ms Welsh moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Welsh submitted that Ms Poblete's actions resulted in actual harm to Resident A which could have further affected the Resident's health. She further submitted that this was not an isolated incident but rather it happened over a period of time until it was detected and escalated by another member of staff.

Ms Welsh submitted that there is no evidence from Ms Poblete of any reflection, remorse, strengthening of practice or other remediation, and as such, there is no evidence to suggest that this behaviour would not reoccur in future.

Ms Welsh submitted that Ms Poblete's actions were deplorable and brought the profession into disrepute.

Ms Welsh submitted that Ms Poblete poses a real and future risk to patients and colleagues if she were allowed to practice unrestricted, as such Ms Welsh invited the panel to find impairment on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: Calhaem v GMC [2007] EWHC 2606 AND Vranicki v The Architects Registration Board [2007] EWHC 1644 in relation to the overlap between cases of deficient performance and misconduct.

**Decision and reasons on misconduct**

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

The panel was of the view that Ms Poblete's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Poblete's actions amounted to breaches of the Code. Specifically:

*'1* **Treat people as individuals and uphold their dignity**
***To achieve this, you must:***

1.2 make sure you deliver the fundamentals of care effectively

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

**3 Make sure that people's physical, social and psychological needs are assessed and responded to**
**To achieve this, you must:**

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

**8 Work co-operatively**
**To achieve this, you must:**

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

**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:**

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

10.2 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

**19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice**
**To achieve this, you must:**

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

**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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered misconduct in relation to each individual charge found proved.

In relation to Charge 1, the panel was of the view that to carry out appropriate reviews and ongoing assessments of a sacral wound is a basic nursing function. This is even more relevant as Resident A was an elderly, frail, vulnerable and a high risk resident who was chair bound and doubly incontinent with a documented history of pressure damage. The panel noted Resident A's diagnosis of dementia made it 'difficult for him to express his thoughts and feelings and wishes regarding his care needs'. The medical concern regarding the sacral area had been documented as an ongoing problem that continued over a period five months. The panel found that as the Deputy Sister Ms Poblete had multiple opportunities for oversight of Resident A's care and failed to act on these opportunities to address the issues. For example, she failed to ensure that monthly reviews of Resident A's care plan 7 (damage to buttocks) were undertaken and the paperwork updated. The result of not performing these basic elements of her role as the Deputy Sister resulted in serious harm to Resident A. The panel is of the view that the failings in this case on the part of Ms Poblete go beyond mere inadvertence or incompetence and are so serious they are properly characterised as misconduct.

In its consideration of Charge 2, the panel considered that the wound assessments and patient care plans are core paperwork, especially in the context of caring for an elderly and frail patient in a nursing home, with a history of skin issues. These basic tasks were clearly not performed and if they had been, a different plan of care would have been implemented. The required assessments and care plans were not completed over a protracted period of time and when there was a duty on Ms Poblete, as the Deputy Sister, to ensure that they were. The panel finds that this amounts to serious misconduct.

The panel next considered misconduct in relation to Charge 3 and it found that the Braden score test was an important but simple and basic pressure ulcer risk assessment tool that should have been carried out on all residents. This was a dedicated single form completed

on a monthly basis and a straightforward and basic review of documentation would have indicated that this was not being undertaken. As Deputy Sister Ms Poblete had oversight and was responsible for checking this and she did not. Given that Resident A had a history of skin problems, a monthly Braden score would have highlighted concerns and put him on a pathway of care for this issue, subsequently preventing the harm to him. The panel finds that this amounts to serious misconduct.

In relation to Charge 5, the panel was of the view that the consequence of not carrying out the assessments meant that Ms Poblete failed to escalate the concern. In her role as the Deputy Sister in charge of the floor that Resident A resided on, Ms Poblete neglected to escalate the concern to senior management at the home, or to follow the clear guidance in relation to escalating the concern to the Tissue Viability Nurse. She did not do this or ensure that another member of staff had done so.

The panel found that Ms Poblete's actions both individually and as a whole did fall seriously short of the conduct and standards expected of the Deputy Sister, and amounted to misconduct.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct, Ms Poblete'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 *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) *…*

The panel finds that Resident A suffered actual harm as a result of Ms Poblete's misconduct. The panel noted that the actual harm to Resident A was over a period of time, and the severity of the wounds should not have got to the stage that they did. It considered that Ms Poblete's lack of action and supervision of the staff on the first floor of the home, and her neglecting to complete the appropriate records, or ensure that they were treated, directly caused harm to Resident A. The panel made reference to the safeguarding report which states that 'pressure damage could have been prevented'. Consequently, the panel finds that the wounds were preventable. Ms Poblete's conduct in neglecting to conduct basic assessments, complete basic records and to escalate concerns in accordance with the relevant guidelines or to, in her role as Deputy Sister, ensure that another member of staff had done so, resulted in harm to Resident A.

In its consideration of the second limb of the Grant test, the panel finds that patients and their families need to be able to trust nurses. Within her role as Deputy Sister within a nursing home, there is an expectation from residents and their family members that someone within her position as Deputy Sister had oversight for overall patient care and safety. Her departure from this could potentially make others hesitant to put family members into the care of nurses.

As such, the panel finds that Ms Poblete's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

After finding that all three limbs of Grant are engaged the panel made reference to Cohen [2008] EWHC 581.

Regarding insight, the panel had no evidence before it to indicate that Ms Poblete has demonstrated remorse for her actions, acknowledged how her actions put patients at risk of harm, or how she would handle the situation differently in the future.

The panel was satisfied that the misconduct in this case is capable of being remediated, as they are clinical management functions. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Poblete has taken steps to strengthen her practice. The panel noted that there is nothing before it to suggest that she has undertaken any training courses. There is also no evidence of any remorse being shown in a reflective statement despite the fact that she received the hearing papers months prior to the commencement of this hearing.

The panel is of the view that there is a risk of repetition based on the lack of evidence from her to suggest that she would not repeat the conduct that led to these regulatory concerns. 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 determined that a finding of impairment on public interest grounds is required because a member of the public knowing the details of this case may be concerned if Ms Poblete was allowed to continue to practice without restriction.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case as the panel made particular reference to a statement made by Resident's A's relative who stated that 'it should not have happened that's their job and they get paid a lot of money to look after

him’. Any member of the public would expect that, given the facts found proved, this conduct should be marked to protect the public and ensure public confidence in the profession. Therefore, the panel also finds Ms Poblete’s fitness to practise impaired on the grounds of public protection.

Having regard to all of the above, the panel was satisfied that Ms Poblete’s fitness to practise is currently impaired.

**Submissions on sanction**

Ms Welsh informed the panel that in the Notice of Hearing, dated 20 February 2025, the NMC had advised Ms Poblete that it would seek the imposition of a 12 month conditions of practice order if it found Ms Poblete’s fitness to practise currently impaired and this still remains the NMCs case.

Ms Welsh took the panel through what she submitted were mitigating and aggravating features in this case. She submitted that the panel should apply the principle of proportionality and that the sanction imposed should not be punitive but should address the issues of public protection in this matter.

Ms Welsh took the panel through the available sanctions and submitted that a 12 month conditions of practice order was the most proportionate sanction in this case.

The panel accepted the advice of the legal assessor.

**Decision and reasons on sanction**

Having found Ms Poblete’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 Sanctions Guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The conduct that led to these regulatory concerns resulted in actual harm to Resident A and put them at risk of further harm.
- Lack of any evidence of insight into failings
- Lack of any evidence of reflection and remediation

The panel also took into account the following features which, although not mitigation, are contextually relevant:

- There were other professionals, senior to Ms Poblete within the Home, who should have also been aware of the ongoing issues regarding the care being provided to Resident A and her failure to fulfil her role as the Deputy Sister.
- Ms Poblete was the Deputy Sister in a Home that was described as 'failing' by the Home Manager.
- The corporate takeover and the increase in occupancy/staff in the Home during the relevant period.

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 Ms Poblete'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 Ms Poblete's

misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the failings identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Poblete's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. In considering the SG the panel considered that the following aspects applied in this case:

- *The panel had not found that there were harmful deep-seated personality or attitudinal problems;*
- *There are identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *There is no evidence of general incompetence;*
- *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 determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel has been informed that Ms Poblete is not currently working in clinical practice, however, should she wish to return to nursing, appropriate safeguards will afford her the opportunity to strengthen her practice, whilst protecting the public.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate and would not be a reasonable response in the circumstances of Ms Poblete's case because it would be punitive and not give Ms Poblete the opportunity to

strengthen her practice. The panel considered it important to give Ms Poblete the chance to return to nursing, with the failings which the panel has found proved addressed, should she wish to do so.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will adequately protect the public and mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a Registered Nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must only work for a single substantive employer or, when working as a bank or agency nurse, you must be allocated to a single place of work for a minimum of 3 months duration where there is a consistency of supervision.

2. You must not be the nurse in charge of any shift.

3. You must have monthly meetings with your supervisor, line manager or mentor to discuss and document your clinical practice in relation to:
    a) Assessment of prevention and management of pressure ulcers.
    b) Escalation of deteriorating residents.
    c) Communication skills with fellow staff and patients

d) Effective care planning and updating of paperwork, including reviews/assessments

4. You must provide a report to the NMC prior to any review from your supervisor, line manager or mentor relating to:
   a) Assessment of prevention and management of pressure ulcers
   b) Escalation of deteriorating residents
   c) Communication skills with fellow staff and patients
   d) Effective care planning and updating of paperwork, including reviews/assessments

5. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

6. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

8. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at a future hearing
- Testimonials from a line manager or supervisor at your place of employment
- Evidence of strengthening of your practice in the areas highlighted
- A reflective statement.

**Interim order**

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Poblete's own interests until the conditions of practice 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 Ms Welsh. She made reference to Article 29(9) and Article 30(1) of the Order and submitted that an interim conditions of practice order would be an appropriate safeguard over the 28 day appeal period or in the event of an appeal until it is determined.

Ms Welsh submitted that Ms Poblete has been subject to an interim order imposed on 5 February 2023, but that this order will lapse upon this panel's decision. Therefore, a fresh interim order would be required for a period of 18 months, to ensure that the public interest and public protection concerns are addressed.

**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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The

conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months. In light of our findings, an interim conditions of practice order will be in the public interest and adequately protect the public.

In the light of her limited engagement the panel cannot be satisfied that Ms Poblete will not or has not formed the intention to take up practice in the short term.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Ms Poblete is sent the decision of this hearing in writing.

That concludes this determination.