Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 5 December 2022 – Friday, 9 December 2022
Wednesday, 4 January 2023, Tuesday 25 July 2023 – Friday 28 July 2023
Thursday 11 January 2024 - Friday 12 January 2024
Monday 22 April 2024 – Friday 3 May 2024
(Thursday 25 April 2024 non hearing day)

Virtual Hearing

Name of Registrant:	Keshwaree Ramana
NMC PIN:	01I9597E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – 12 November 2004
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Geraldine O'Hare (Chair, Lay member) Lorna Taylor (Registrant member) Ian Dawes (Lay member)
Legal Assessor:	Attracta Wilson (5-9 December 2022 & 4 January 2023) Robin Ince (25 – 28 July 2023, 11 & 12 January 2024 & 22 April 2024 – 3 May 2024)
Hearings Coordinator:	Amira Ahmed (5-8 December 2022 and 04 January 2023) Chantel Akintunde (9 December 2022) Daisy Sims (25 July 2023 – 28 July 2023) Christine Iraguha (Thursday 11 & Friday 12 January 2024) Rene Aktar (22 April 2024 – 3 May 2024) Samantha Aguilar (26 April 2024)
Nursing and Midwifery Council:	Represented by Yvonne Ferns, Case Presenter (2022 and 2023)

	Represented by Hazel McGuinness (11 & 12 January 2024 & 22 April 2024 – 3 May 2024)
Mrs Ramana:	Present and represented by Rajoo Ramana (5-9 December 2022) Not present and not represented (4 January 2023) Present and represented by Rajoo Ramana (25 – 28 July 2023, 11 & 12 January 2024, 22 April – 3 May 2024)
Facts proved:	**All charges**
Facts not proved:	**N/A**
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge (as amended)

That you a Registered Nurse, while a Director at BSR London Limited, which owned and ran Chesterholme Lodge **between August 2017 and 24 December 2019**:

1. Failed to adequately safeguard residents in that you did not ensure that:

a) There were sufficient numbers of suitably qualified staff to meet the service user's needs;

b) Staff had received appropriate training;

c) The Mental Capacity Act 2005 was understood and/or applied by staff;

d) Residents' privacy and dignity was promoted;

e) Residents were provided with a clean and hygienic environment;

f) Residents' nutritional needs were met;

g) Residents' care needs were assessed and/or met;

h) Effective systems was in place to ensure residents' health and safety;

i) Effective systems were in place to safeguard service users from abuse and/or improper treatment.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Ferns, on behalf of the NMC, to amend the wording of the stem of the charges.

The proposed amendment was to add the wording 'between August 2017 and 24 December 2019' after the word 'Lodge'. It was submitted by Ms Ferns that the proposed amendment would provide clarity and more accurately reflect the evidence.
Proposed amendment:

“That you a Registered Nurse, while a Director at BSR London Limited, which owned and ran Chesterholme Lodge **between August 2017 and 24 December 2019**”

Mr Ramana on your behalf did not oppose this application.

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’ (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

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

On 4 January 2023, Ms Ferns drew the panel’s attention to an email from Mrs Ramana received by the NMC on 2 January 2023 stating that she would like a postponement of the hearing [PRIVATE] should be heard in private and Ms Ferns did not object to the application under Rule 19 of 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 of any third party or by the public interest.

The panel determined that all parts of the hearing [PRIVATE] and the record of such references shall be marked as private.

Application for an adjournment on 4 January 2023

Ms Ferns presented the panel with an email from Mrs Ramana on 2 January 2022 stating that she would like a postponement of the hearing [PRIVATE].

Ms Ferns submitted that this email can be taken as an application for an adjournment under Rule 32. She submitted that the NMC's position is neutral in regard to this application, and it is a matter for the panel to decide on whether or not to grant it.

Mrs Ramana's email dated 2 January 2023 stated:

> *"[PRIVATE].*
>
> *..*
>
> *We are therefore kindly asking to push the meetings starting on the 4th to W/C 9th January."*

The panel accepted the advice of the legal assessor. She advised the panel that it should consider the application with the utmost care and caution. She referred to Rule 32 of the Rules. She advised the panel that it should consider the public interest in an expeditious hearing, any potential inconvenience to the witnesses and whether an adjournment would result in any injustice to either party or in any unfairness to Mrs Ramana. She reminded the panel of Mrs Ramana's right to a fair hearing and her right to hear and respond to the case against her.

The panel noted that a witness was due to attend the hearing this week and had been notified of the potential for this hearing to be adjourned. It also noted that Mrs Ramana is willing to attend the hearing today with her son as support. As her son is a potential witness in this case, the panel determined that this would not be appropriate. The panel further noted that Mr Ramana is not only Mrs Ramana's representative, but he also provides support for her due to her hearing impairment. [PRIVATE], it would be unfair to continue the hearing without Mrs Ramana's chosen representative being present today.

The panel decided that, on balancing all factors and taking fairness into consideration, it would allow Mrs Ramana's application for an adjournment to afford her the opportunity to attend the hearing at a future date and be represented. It determined that any inconvenience to the NMC or its witness was outweighed by Mrs Ramana's entitlement to a fair hearing.

The panel did canvass whether Mrs Ramana would be able to attend the hearing this Friday 6 January 2023 [PRIVATE]. Mrs Ramana confirmed by telephone that this would not be possible.

Interim order

Ms Ferns submitted that Mrs Ramana is not subject to an interim order. She submitted that because of the stage the hearing is currently at, she does not propose to make an application for an interim order. She submitted that it is up to the panel as to whether it determines an interim order is necessary at this stage.

The panel accepted the advice of the legal assessor.

The panel noted that an interim order had not been applied for by the NMC. It determined that, before any interim order could be imposed, it would have to be satisfied of the necessity for such an order. In the absence of submissions from the NMC, the panel could not be so satisfied and determined that an interim order was not currently necessary on the grounds of public protection, in the wider public interest or in Mrs Ramana's own interests.

Further amendment of charge during in camera fact finding

Whilst considering whether the facts alleged had been found proved or otherwise, the panel noted a grammatical error in the wording of charge 1h) which read *"effective systems* <u>*was*</u> (the panel's emphasis) *in place to ensure resident's health and safety."*

The panel was advised by the legal assessor of its power to amend any charge under Rule 28 (1). *"At any stage before making its findings of fact."* The panel considered that, amending the wording of the charge to read, *"effective systems were in place…"* would not cause any injustice since it was merely correcting a grammatical error, so therefore made such an amendment without referring the matter back to the parties.

Background

Your name was entered on the NMC register in 2004. You were a Director of BSR London Limited ("BSR") which owned and ran Chesterholme Lodge residential home ("the Home") from 24 August 2017 until the Home's closure in late December 2019. In accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations") BSR was regarded as the *"Service Provider"* and was also the *"the Registered Person"* since it was the body registered with the Care Quality Commission ("CQC") as being the owner of the Home. As such, BSR was required (under Regulation 6) to *"take all reasonable steps to ensure that the nominated individual"*, inter alia *"the necessary qualifications, skills and experience to properly supervise the management of the carrying on of the regulated activity."* Further, BSR was required to give notice to the CQC as to the identity of the *"nominated individual"* who was *"responsible for supervising the management of the carrying on of the regulated activity of the body."* The nominated individual was your son, Witness 5.

Further, Regulation 8 stated that the registered person (BSR) *"must comply with Regulations 9 and 19 in carrying on any regulated activity."* The regulated activities under Regulations 9 to 19 were: person centred care; dignity and respect; need for consent; safe care and treatment; safeguarding service users from abuse and inappropriate treatment; meeting nutritional and hydration needs; premises and equipment; complaints; good governance; staffing; and employing fit and proper persons.

In essence, BSR, of which you were a Director, was responsible for meeting the required standards at the Home. Moreover, the panel heard from witnesses who stated that, in any

event, you as a Registered Nurse had a duty of care under *‘The Code: Professional standards of practice and behaviour for nurses and midwives (2015’* (“the Code”) in relation to the care and wellbeing of Residents within the Home. The panel heard about a Day Centre that you owned and had responsibilities for.

On 25 March 2019, a CQC inspection rated the Home as *‘Good’*. On 18, 20 and 26 November 2019, a further CQC inspection at the Home was carried out by Witness 1. This was in response to two separate concerns being raised about the Home by third parties.

In September 2019, the Home’s Registered Manager left the organisation and the subsequent newly appointed manager left after one week. Witness 5 was the nominated individual and took on the role of Home Manager whilst a replacement was sought. Witness 4 was appointed as the Home Manager in November 2019 with a view to becoming the Registered Manager but that was dependent on Local Authority permission being granted, but this never happened.

The CQC inspection in November 2019 rated the Home as *‘Overall Inadequate’*. You were present on at least one day of the inspection and told Witness 1 that you were *‘heavily involved’* with the Home.

Issues identified by Witness 1 included:

- insufficient numbers of suitably qualified staff
- staff had not received appropriate training, meaning that residents’ needs were not always supported safely
- mental capacity assessments not completed and residents were restricted from accessing their money without lawful jurisdiction
- lack of privacy and dignity
- inadequate or absent care plans and risk assessments
- failure to manage risk.

Witness 1 also found that residents were not protected from abuse and were placed at risk of institutional abuse and neglect, for example, there was lack of access to food when required, and you had not ensured that staff had completed training in safeguarding.

Witness 1 has exhibited a number of photographs, including:

- the staff comments book and food stocks, illustrating issues with lack of food
- residents' rooms which appear dirty and untidy
- dirty and damaged furniture
- a cubicle with no shower curtain

Witness 1 found that, as one of the directors at the Home, you had a joint responsibility with the other proprietors to ensure that care and treatment at the Home was provided in a safe way. It was expected that systems and procedures would be put in place to meet that responsibility.

Witness 2 visited the Home on 23 December 2019 following further concerns from the Local Authority and identified a number of concerns including:

- inadequate staff on duty
- the Home was unclean with a strong odour of cigarettes and faeces
- resident's rooms were dirty
- medication was unsecured
- failure to ensure resident's dignity, such as no door in en-suite bathrooms
- broken electrics putting residents at risk.

Witness 2 found that the concerns identified were very serious. Witness 2 explains their opinion that as a registered nurse and a director, you had a duty to identify risks of harm to residents and report concerns using the correct processes.

Witness 3 worked in the same team as Witness 2. She undertook visits to the Home on 11 and 16 December 2019 following additional concerns being raised by a Care Coordinator. Issues identified by Witness 3 included:

- staffing levels being too low
- lack of guidance or training for oxygen therapy or caring for an epileptic resident
- inadequate care plans putting residents at risk.

Witness 4 also made a referral to the NMC about their concerns. Witness 4 stated that you would regularly visit the Home when they were in post. Witness 4's concerns included:

- insufficient staffing, meaning that residents were left unsupported and had to go without drinks or food for a significant time, as staff were unavailable to provide support
- insufficient training
- no Deprivation of Liberty Standards in place where required
- the Home was in a state of disrepair and residents were living in 'squalor'
- no personal evacuation plans for residents.

Decision and reasons on facts

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

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

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

- Witness 1: Inspector for the Care Quality Commission (CQC)

- Witness 2: Designated Nurse for Safeguarding Adults and Head of Vulnerable Adults at South Eastern Hampshire and Fareham and Gosport Clinical Commissioning Group (CCG)

- Witness 3: Clinical Quality Facilitator for Safeguarding for South Eastern Hampshire and Fareham and Gosport Clinical Commissioning Group and Registered Nurse

- Witness 4: Manager of Chesterholme Lodge (November-December 2019)

The panel heard live evidence from both you and a witness called on your behalf:

- Witness 5: Your son

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

The panel noted the basis of your denial of the charges. You maintained that you had only been appointed as a Director of BSR to facilitate the granting of a loan to the company and that you were in effect, a *"silent partner"* who was not involved in the running or the management of the Home. You were yourself solely responsible for running a separate care establishment, but Chesterholme Lodge was always intended to be the responsibility

of your son, Witness 5 (with your husband assisting him with regard to maintenance duties.)

Further, the panel noted the evidence of Witness 5 who maintained that he did not want you to be become involved in the running of the Home. Having said that, the panel also notes that you accepted, in hindsight, that, as a Director of BSR, you did have responsibilities with regard to the running of the Home and that, especially as you are a nurse, you should have become involved. However, you maintained that, at all relevant times, you were unaware of such responsibilities.

You told the panel that you found elements of the CQC report focused on the negative and ignored the positive findings. You explained that you felt that a lot of the inspection findings were *"made up"* and that the staff were working against your family. This was supported to some extent by the evidence of Witness 5.

The panel considered the witness and documentary evidence provided by both the NMC and Mr Ramana.

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

> 'That you a Registered Nurse, while a Director at BSR London Limited, which owned and ran Chesterholme Lodge **between August 2017 and 24 December 2019**:'

This preamble is found proved.

The panel noted that there was no dispute between the parties in relation to these background facts. You have accepted that between 24 August 2017 and 24 December 2019, you were a Director of BSR which owned and ran Chesterholme Lodge. The panel therefore found this part of the charge proved.

The stem of Charge 1

1. Failed to adequately safeguard residents in that you did not ensure that:

The panel first considered the stem of this charge, namely *"failed to adequately safeguard residents in that you did not ensure that…"* The panel noted that the use of the word *"failed"* indicated that the NMC allege that you had a duty to *"ensure"* that *"residents"* at the Home were *"adequately"* safeguarded.

In accordance with the advice from the legal assessor, the panel has therefore first considered whether you had such a duty. The panel noted that, as a Director of BSR, you had a number of responsibilities under the regulations (as set out above). You indicated that, at the relevant times, you were unaware of such responsibilities. However, the panel accepted the advice of the legal assessor that *"ignorance of the law was no excuse"* and that therefore you had a duty under the regulations as a Director of BSR to comply with the requirements set out in regulations 9-19, which are reflected in the allegations specified in charges 1(a) to (i). Further, the panel notes that you now accept that you should have been aware of your obligations as the Director of BSR, which the panel has taken into account as an admission to the stem of the charge.

Finally, the panel also considered that, as a registered nurse, you had in any event a duty under the Code to safeguard residents with respect to any matters which came to your attention during, for example, your admitted visits to the Home. In reaching this conclusion, the panel relied upon the evidence from Witness 2 and Witness 3 who in summary, were of the view that you as a registered nurse had a duty of care to meet Residents' basic needs, safety and wellbeing.

The panel determined that in particular, during the time the Home did not have any manager in post, your responsibilities as a director and as a registered nurse became

much more critical. The panel determined that either you knew about certain aspects regarding the failures in care at the Home or that you should have known.

Accordingly, in respect of both your obligations as a director of BSR, and as a Registered Nurse under the Code, the panel finds the stem of this charge proved, subject to whether it finds the individual factual matters set out in sub paragraphs 1(a) to (i) proved. The panel considered that, if found proved, each of the matters alleged in those sub paragraphs, individually and/or collectively, amount to a failure to adequately safeguard residents.

Charge 1a)

> a) There were sufficient numbers of suitably qualified staff to meet the service user's needs

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witnesses 1, 2, 3 and 4. The panel saw a range of corroborative and contemporaneous evidence and exhibits which it considered alongside the oral evidence. The panel also took into account both your evidence and the evidence of Witness 5.

The panel took into account Witness 1's statement in which she touches on the relevant regulations that are important and that there were staffing issues. Witness 1 stated:

> *"We found that there were insufficient numbers of suitably qualified, competent, skilled and experienced staff who were deployed to meet people's needs. For example, on 18 November 2019 there were four staff members, only two of which were care staff, to care for fifteen service users, the other two being a cook and a housekeeper. On all three days of the inspection, staff members were observed not*

to have the time they required to provide service users with responsive and effective care in line with their specific needs and requirements.

Staff members and residents spoken to by myself and the other inspectors throughout the inspection felt there was not enough of them to meet the service users' needs. Comments made by service users included one service user stating that they "think they [the Home] are definitely short staffed", further comments made by service users are detailed at paragraph C2.15 OF Exhibit MC12. Staff members made statements including "there is not enough staff at the moment", further comments made by staff members are detailed at paragraphs C2.16 to C2.18 of Exhibit MC12. The Providers were unable to demonstrate that there were enough staff in place to meet service users' needs or that staff in place had the required skills and knowledge."

The panel also took into account the Chesterholme Lodge CQC Inspection Report dated 24 December 2019 which detailed examples of how many staff were assigned to each shift. The report stated:

"● The service employed an activities coordinator for 16 hours per week, who stated working at the service on the first day of the inspection. We discussed their role with them and they told us they would be; "Spending time out and about with people, taking people shopping and to appointments." They also confirmed for people who were unable or declined to go out they would spend time with them, talking to them or playing card or dominos.
● Staff told us they did not have the time to complete activities with people."

The panel took account of numerous shift rotas and sign in documents which set out staffing levels during the relevant period.

Witness 2 set out in her visit to the Home;

'[…] I found that staff appeared very busy trying to keep the Home running, sorting food and medications, supporting residents and attending to visitors. There were two carers on duty and the Manager, which did not appear to be an adequate number of staff. When speaking to the Manager about staffing at the Home they explained that the owners, including the Nurse, set up interviews for people and employed agency staff without the Manager or Deputy Manager's input.'

Witness 3 set out in her witness statement;

'I also had concerns about staffing levels at the Home being too low, as [Witness 4] *advised me that they had vacancies and were continually utilising agency carers. After the visit concluded, I sent a link for advertising vacancies on NHS jobs website as well as training resources links to* [Witness 4]*.'*

The panel heard evidence from Witness 4 in both written and oral form that you felt the staffing levels in the Home during his tenure as manager was insufficient. Witness 4 was experienced in this care setting and his evidence corroborated that of other witnesses. Witness 4 also provided evidence that subsequent to the CQC inspection staffing levels at the Home were increased from two care staff on duty to three care staff per shift.

The panel further took into account your statement where you stated:

"It's my understanding that there were the following staff members on shift on a typical weekday: Manager, Administrator, cook, 2 care givers in the morning, 2 care givers in the afternoon, 2 care givers in the evening, 1 housekeeping staff, 1 activities person. Daily sign-in sheets can be attached from 2017 if needed.

[Witness 1] stated that a previous manager had left [PRIVATE] and because my son refused to recruit more staff members. Attached is an email from the said

manager (PRIVATE) [PRIVATE] in the same email it shows my son telling her of the numerous staff members being recruited and to add them to rota's."

The panel heard evidence from you that Witness 5 was trying to address the staffing issues by recruiting new members of the team and also utilising agency staff. Witness 5 told the panel that it was his sole responsibility to manage the staffing levels and shift rotas at the Home.

The panel also notes that Witness 5 accepted, in an email exhibited as 'MC8' that the Home was short staffed and that you ultimately confirmed in your oral evidence that two care staff per shift looking after the 15 residents in the Home was insufficient. The panel further noted that you suggested that Witness 4 had deliberately attempted to cancel agency staff to make the Home appear understaffed to visiting professionals. However, the panel found this was not plausible given that Witness 4 had already reported concerns regarding staffing levels.

The panel considered that there was evidence before it from a number of witnesses, on various days, who gave consistent accounts of finding a shortage of staff in the Home. The panel found that you should have been aware of difficulties with staffing levels particularly since you were a registered nurse who visited the Home regularly. Finally, taking into account your own admission about the staffing levels being inadequate, the panel concluded that residents' needs were not being met adequately. The panel determined that you had failed to ensure that there were sufficient numbers of suitable qualified staff to meet the service user needs.

The panel therefore found this charge proved.

Charge 1b)

b) Staff had received appropriate training;

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witnesses 1, and 4. The panel heard corroborative oral evidence to support this charge. The panel also took into account both your evidence and the evidence of Witness 5.

The panel heard and accepted Witness 1's oral evidence and took into account that the staff had not received appropriate training with regard to medication. The panel noted that there were no updates in relation to training relating to safeguarding. Witness 1 in her statement detailed:

> *"We found that the training records showed that staff had not received appropriate training in a timely way to enable them to carry out the duties they are employed to perform. For example, the training matrix showed that:*
> *- Staff members 6 and 8 had not received medicine training*
> *- Staff members 1 and 4 had not had their medicine training updated in a timely way.*
> *- On the 18 November 2019 Staff members 6 and 1 were on shift together and were administering medicines. The training matrix indicated that neither of these staff were trained to do so.*
> *- Staff member 1,3,4 and 6 did not have up to date safeguarding training*
> *- Staff members 1,2,3, and 4 did not have fire awareness training*
> *- Staff members 1, 6 and 9 did not have up to date infection control training.*
> *- Staff members 1,2,3,4,6 and 9 did not have up to date moving and handling training*
> *- Staff members 6 and 9 did not have up to date food hygiene training."*

The panel heard that Witness 1 had asked for the training records to be provided within 7 days, but they were not provided.

Witness 4 stated in his statement:

'[…] I looked into the medication training provided to staff at the Home and found that they had only completed basic online training, which I did not deem sufficient for staff to administer medication to residents. I would have expected staff to have face to face medication training, followed by three supervised rounds of medication handling, to be able to carry out medication rounds independently.'

Witness 4 also described his own training on become the Home Manager where he stated that there was no induction and that he was given only a brief handover.

The panel noted Witness 5's email response to Witness 4 dated 29 November 2019 in which he wrote, *'happy to book the face-to-face training. I think it would be a necessity. I will also be participating. If you have a company in mind please suggest it and suggest a date you would like to book it in for.'*

In your evidence, besides you maintaining that training was solely a matter for Witness 5, you told the panel that you were unable to obtain a full training matrix from the training provider as it was over three years since the training had taken place. The panel interpreted your response and that of Witness 5 as an acceptance that training was not up-to-date and therefore was not appropriate.

The panel determined that as you were a Director of the Home, you had an oversight on the issues, and irrespective of whether you were aware of such matters, you should have been aware that there were not adequately trained staff on duty.

The panel therefore found this charge proved.

Charge 1c)

c) The Mental Capacity Act 2005 was understood and/or applied by staff;

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witnesses 1, 3 and 4. The panel saw a range of corroborative and contemporaneous evidence and exhibits which it considered alongside the oral evidence. The panel also took into account both your evidence and the evidence of Witness 5.

Witness 1 stated:

> *"One of the service user's (Service User H) bank card had been locked in the service safe. There was no record of information about why this service user's bank card had been locked away. During the inspection we were told that they wanted to access their bank card for three days. Staff members on shift did not have the access code for this safe so were unable to get the bank card on their behalf. Restricting service users to have access to their money without lawful jurisdiction is an infringement of their rights.*
>
> *We discussed a service user's level of capacity with the Nominated Individual in relation to them remaining at home (Service User J). The Nominated Individual stated that a Mental Capacity Act had been completed. However, there was no evidence of this on file.*
>
> *In relation to a third service user, Service User E, there was no Mental Capacity Act assessment or best interest decision recorded to demonstrate that this service user lacked capacity to manage their own medicines or was being supported in the least restrictive way."*

Witness 3 corroborated the evidence as outlined above.

The panel took into account Witness 4 in which he stated:

"When I started at the Home I found that restrictions were imposed on some residents, such as the food being locked away, although there were other restrictions on individual residents too. Due to the passage of time I cannot recall what these exact restrictions were. When I looked into this I found that no Deprivation of Liberty Safeguards were in place, which are used when a Mental Capacity Act assessment has been carried out and the resident has been assessed as needing to have restrictions in place, so the restrictions were essentially illegal."

You told the panel that you did not know if the staff had received the relevant training on the Mental Capacity Act. In relation to capacity and medication management, you told the panel that you had seen the relevant documents in a folder. You accepted that training on the Mental Capacity Act was necessary for the staff working in the Home.

The panel noted the staff training policy which you produced in evidence dated September 2019. There is no mention of any Mental Capacity Act training within the body of that document.

Given that you are a Registered Mental Health Nurse, the panel considered that your responsibility in relation to this charge relates to both you being a registered nurse and your role as a director. The panel are of the view that given this an area in which you have specific expertise, the panel considered it not plausible that you would not ensure that staff understood or applied the Mental Capacity Act.

The panel noted that you disputed handling monies for residents and stated that staff on duty had keys to access the relevant safe for service user H's bankcard. The panel preferred the evidence of the NMC witnesses to your account, supported as it was by contemporaneous documentation.

The panel took into account that a resident was not able to access their funds. The panel noted there was nothing to suggest that there was awareness from staff around the Mental

Capacity Act and issues surrounding capacity. The panel therefore determined that you had failed to ensure the Mental Capacity Act was understood and/or applied by staff.

The panel therefore found this charge proved.

Charge 1d)

d) Residents' privacy and dignity was promoted;

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witnesses 1, and 2. The panel saw a range of corroborative and contemporaneous evidence and exhibits which it considered alongside the oral evidence. The panel also took into account both your evidence and the evidence of Witness 5.

Witness 1 in her witness statement detailed:

"On 20 November 2019, we identified some areas of the environment did not help service users to support their privacy and dignity. For example, there was no shower curtain in place within the bathroom and in bedroom nine a shower curtain was being used to cover a patio door which looked out onto the garden. I attach images of the shower and patio door as Exhibits "MC13" and "MC14", respectively."

The panel heard evidence from Witness 1 that the resident in that particular room with the shower curtains stated, *'it has been like that for ages'.*

Witness 2 set out in her witness statement:

'I also looked in two of the ensuite rooms at the Home, and found that it did not have a completely separate bathroom as I was expecting, but rather a

> *half height wall with no door. One of the rooms had a strong odour of urine, which I felt was suggestive of a UTI, so I highlighted my concerns to the Manager for them to review that resident. In the other ensuite room there was a strong smell of faeces.'*

The panel noted that residents regarded the Home as their personal home. The panel considered the removal of the shower curtain and not replacing it in a reasonable time amounts to causing a lack of dignity.

Your evidence was that the material on the window, described as being a shower curtain, was in fact a curtain, and that the resident in the room had broken the curtain pole. You told the panel you had never seen an open toilet cubicle in any room and questioned why photographs had not been taken of this.

The panel noted that during the dates of the CQC inspection in December 2019, the shower curtain in question was replaced.

The panel also took into account the photographic evidence in relation to the toilets and rooms in which privacy and dignity was compromised. The panel determined that the photographic evidence supported the witnesses' accounts that highlighted the dirty, cluttered environment, damage furniture and flooring and stained bedding and concluded that this could impact adversely upon residents' dignity.

The panel considered that as a registered nurse and a director who regularly visited the Home, you should have been alerted to these issues and had a responsibility to act in relation to residents' privacy and dignity.

The panel therefore found this charge proved.

Charge 1e)

e) Residents were provided with a clean and hygienic environment;

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witnesses 1, 2 and 4. The panel saw a range of corroborative and contemporaneous evidence and exhibits which it considered alongside the oral evidence. The panel also took into account both your evidence and the evidence of Witness 5.

The panel took into account Witness 1's statement:

> *"Aside from fire risk, we also identified that the Providers had not identified the environmental risk posed by the state of bedroom nine, which was very untidy and had mouldy food within, which could have attracted vermin.* […] *By continuing to allow bedroom nine to be left in the condition it was, the Providers were failing to mitigate serious risks to all service users within the Home. These concerns were raised with the Providers. I cannot recall if the Nurse was present on 20 November 2019, at which time we were informed that the service user occupying bedroom nine refused to let staff in to support them to tidy. However, they were unable to provide any evidence that attempts had been made to address this issue and the wider impact and risk to others at the Home, or that these risks had been considered."*

Witness 1 further stated:

> *"The Nominated Individual was unable to provide us with evidence that an annual infection control statement had been completed since 2016. Under Regulation 12(2)(h) of the Regulations, the provider must assess the risk to prevent, detect and control spread of infections.* […] *As the providers had not produced an up to date annual infection control statement and failed to demonstrate that they could meet Regulation 12(2)(h), the providers failed to follow the Code of Conduct."*

The panel also took into account Witness 2’s statement:

> *“My first impression of the Home on arrival was that it was very unclean and had a strong odour of cigarettes and faeces. During the visit I spoke to a number of residents, many of whom told me that they did not like living at the Home and that ‘the whole home had gone downhill’, or words to that effect, since the new proprietors, including the Nurse, had taken ownership of the Home.”*
>
> *“I do believe that there is a shared responsibility for the failings in this situation, to which I suggest the Nurse has some responsibility to have overseen in her capacity as proprietor and for some period, taking a management role within the Home. I find it challenging to accept that a nurse could have attended or had knowledge of the environment I observed, without recognising a duty of care to make efforts to improve the situation for the vulnerable adults who lived and received care there.”*

The panel took into account Witness 4’s statement;

> *“[…] When I started the role, and attended the Home for the first time, I was shocked by the state of disrepair it was in. The residents were essentially living in squalor. In particular, I found that the beds were dirty and there were cigarette burns all over the floor.*
> *[…]*
>
> *The state of disrepair made it clear that there had been issues at the Home for some time, as it was clear that the Home could not have gotten into that state in a short period of time.*
>
> *On one occasion, I do not recall the date, I sat down with all of the Proprietors, including the Nurse, and spoke to them about the state of the Home and how serious I felt the situation was, as I considered them to be*

jointly responsible for keeping the Home in a good state of repair as Proprietors. I recall that they said they would get back to me, however, as with my other requests I never got a positive response from voicing my concerns and no changes were actioned."

The panel noted your and Witness 5's evidence that the resident in Room 9 did not want her room to be cleaned and would not let anyone in to do so, but also notes other evidence that suggested that the resident was happy to have the room cleaned, providing she was present. However, the panel considers that, you still had a duty, not withstanding that resident's objections, to ensure that they were provided with a clean and hygienic environment.

The panel took into account your evidence and that of Witness 5 in that you had undertaken some work within the Home to make improvements to the environment for residents. The panel heard that steps had also been taken to try and manage the resident in room 9, however, the panel considered these steps were insufficient and ineffective. However, the panel considered that this was insufficient given the problems highlighted within the evidence highlighted before it.

The panel considered that as a registered nurse and a director who regularly visited the Home, you should have been alert to these issues and had a responsibility to act in relation to residents' privacy and dignity.

The panel were persuaded by the evidence from the NMC's witnesses.

The panel considered that there was consistent documentary evidence to demonstrate that residents were not being cared for in a clean environment. The panel took into account that Witness 1 and 2's evidence corroborated the photographic evidence that was provided to the panel.

The panel therefore found this charge proved.

Charge 1f)

f) Residents' nutritional needs were met;

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witnesses 1, 2, 3 and 4. The panel saw a range of corroborative and contemporaneous evidence and exhibits which it considered alongside the oral evidence. The panel also took into account both your evidence and the evidence of Witness 5.

The panel noted Witness 1's statement where she stated:

"[…] *For example, during the inspection we found that, as explained above, service users could not access food when required because the Providers had implemented restrictions on the access of food to both staff and service users.*

[…]

The Nurse was one of the proprietors of the Home, and a Director of the Company. I had little knowledge of them prior to meeting them during our inspection of the Home in November 2019, as discussed below. During this inspection the Nurse informed me that they were heavily involved with the Home, although I could not ascertain what their exact day to day role was, apart from that they managed the food orders for the Home.

[…]

the communal food store was locked and staff did not always have access to keys for the locked away food. Service users' food choices were restricted. During the visit on 18 November 2019, service users asked whether we

could "do something about the food". The overall food stocks in the home were very limited."

Witness 1 also exhibited photographic evidence of the fridges and cupboard which contained very little food.

It also noted Witness 2's statement:

> *"Before conducting the visit on 13 December 2019, my team was informed of further concerns raised by a Community Psychiatric Nurse (CPN),* […]*, on 10 December 2019, who had visited the Home. They had identified concerns and called the CCG to share this information. The concerns were that staff had complained to them about the owners' attitude being predominantly business minded, that there had been multiple managers, the kitchen door was being locked preventing residents from accessing food and drink, and staff were whistleblowing."*

The panel further noted Witness 3's statement when she set out the nutritional needs of a resident with insulin dependent diabetes:

> *"*[…]*On 16 December 2019 I reviewed Service User A's care documentation, which was held on the electronic system at the Home, which showed that on four days in the previous week they had not been administered any insulin, despite them being an insulin dependent diabetic. I do not hold any copies or photographs of this care documentation as it is not within my remit to retain patient information, as above. The care plan also included no information as to what staff, or Service User A, should be aiming for in terms of blood glucose levels. I was further concerned when I was informed by a staff member, whose name I do not recall, on 16 December 2019 that Service User A was also refusing food, putting them at further risk with regard to their diabetes."*

Witness 3 further stated:

"In my professional opinion, I would expect a registered nurse to provide, at the very least, the basic necessities of life, and in failing to provide sufficient […] and food, the Nurse, alongside the other proprietor and Nominated Individual, although they are not registered nurses, failed to do this. To learn that one of the Home's proprietors was a qualified nurse was shocking. I do not feel that they were adhering to the NMC code of conduct in any way."

The panel further noted Witness 4's oral evidence. Witness 4 stated that you:

"would tell me what to buy, how much to buy, and how much to give out. I remember hot dogs, she would tell me to buy, "each resident gets two hot dogs each day, each tin contains eight sausages, so you need to buy four for the week for one meal… The food was being controlled quite heavily. There was a very strict how much you can give and how much you can buy. It was being locked away without any reasonable reason for it to be locked away and no official papers, such as MCAs being done, or DoLS in place to restrict that. I believe there were some concerns about weight losses amongst residents. Residents regularly complained about the food and the amount of food that they were getting".

The panel appreciates that the evidence also indicated that some residents were satisfied with their food allocation, in particular at the time of the CQC inspection. It also noted that there were times when there were significant complaints from resident and staff about the quantity and access to food.

You told the panel that there were other food stores, fridges and freezers containing food which were not photographed during the investigation. You told the panel that the cook was responsible for setting menus and you denied that the food was locked away. The panel were provided with evidence of menus and food orders with the companies that supplied the Home. Witness 5 set out the home manager was responsible for buying the food with the company credit card.

The panel noted your evidence that you were not involved in the ordering or management of the food in the Home. You gave detailed response in relation to questions around this topic but denied being involved in the Home or with the residents' nutritional needs. The panel found your evidence inconsistent and at times contradictory for example, when you described the kitchen, setting out diabetic dietary needs and your knowledge of the cook catering for special diets individually despite denying having any involvement in these matters.

The panel took into account all of the witnesses' statements and the photographic evidence. The panel determined that there was sufficient evidence to indicate that residents' nutritional needs were not being met and that there was a recurring theme of consistent evidence from a number of residents complaining about not receiving sufficient food.

The panel considered that as a registered nurse and a director who regularly visited the Home, you should have been aware of these issues relating to food and had a responsibility to act so as to ensure the residents' nutritional needs are met.

The panel therefore found this charge proved.

Charge 1g)

g) Residents' care needs were assessed and/or met;

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witnesses 1, 2 and 3. The panel saw a range of corroborative and contemporaneous evidence and exhibits which it considered alongside the oral evidence. The panel also took into account both your evidence and the evidence of Witness 5.

The panel took into account Witness 1's statement where she quoted Exhibit MC5 which was the referral from a previous employee setting out concerns regarding the welfare of residents, particularly their social needs not being met. This was part of the initial concerns which prompted the unannounced CQC inspection in November 2019.

The panel also had regard of Witness 2's statement where she stated:

> *"On 16 December 2019,* [Witness 3] *conducted the further visit to the Home to conduct reviews for the CCG funded residents with [PRIVATE]. Their report of the visit is set out in row 28 of the chronology document (Exhibit LO2). During the visit* [Witness 3] *reports that they had concerns about omission of insulin for one of the CCG's residents. They also found that there were concerns with care planning, medications management and management of long term conditions, such as epilepsy. One person was found to have had their insulin omitted for four days, with their diabetes care plan not providing an outline for appropriate blood sugar ranges. There were concerns that another resident reviewed was not having their pain adequately managed as although they were on patches, PRN codeine was administered regularly and for long periods of time; addiction to this medication was raised as a concern to the GP. A resident who was reviewed was found to have received the incorrect dosage of anti-psychotics; it was unclear whether this led to harm for the person. Staff were unaware that one resident had epilepsy, with there being no epilepsy plan, staff training or prn protocol for seizures."*

The panel had sight of Witness 2's statement where she stated:

> *"Staff had not completed training in supporting service user's specific needs which meant these needs were not always supported safely. This resulted in a negative impact on service users.*
>
> *…*
>
> *Another example was that a staff member had told us that Service User B had experienced an episode of breathing difficulties on 6 November and they were still*

unwell. There was no record of a care plan or risk assessment in place highlighting this, nor was there any guidance for staff of signs and symptoms to look for should they suspect Service User B's breathing become compromised."

Witness 2 in both in her written and oral evidence provided details of Service User A who for four days had not received any insulin, despite being an insulin dependent diabetic. Service User A was also refusing food at this time which put them at further risk.

The panel further had regard of Witness 3's statement where she stated:

> *"One of the residents, Service User E, was epileptic. When speaking to [PRIVATE] it became clear that they were unaware of this, [PRIVATE] confirmed staff were not trained in caring for an epileptic resident and, that there was no epilepsy plan for Service User E in place. I would expect for a plan to be in place which sets out medication to be administered, for example, in the event that Service User E had a seizure.*
>
> *Epilepsy requires a specific care plan in a care home setting so that staff are able to intervene if a seizure occurs. It would be the Nurse's responsibility, alongside the other proprietor, to ensure the staff were able to manage a seizure if one occurred. Failure in this would have potentially led to a unnecessary hospital admission or complications arising from epilepsy such as SUDEP (sudden death in epilepsy)."*

In relation to Service User C, the panel heard that codeine patches were being used for a prolonged period with no record of pain management being available to the inspection team. Staff did not appear to be aware of the risk of addiction in relation to regular and sustained use of this medication.

The panel heard from you that you had no responsibility in the care needs of the residents. You told the panel that care plans were no longer available to you and you questioned why Witness 3 had not taken photographs of the documents pertaining to the resident with

Type 1 Diabetes. Witness 5 told the panel he had sought guidance with regards to the care of resident on oxygen from a clinician friend.

The panel took into account all of the witnesses' evidence and concluded that all of these observations took place on different days. The panel noted that although there were a number of people that had direct responsibility for the Home, no one took direct responsibility. The panel also noted that due to staff either not being trained or due to a lack of staff, it appeared that many of the residents' care needs were not being met.

The panel considered that as a registered nurse and a director who regularly visited the Home, you should have been alert to these issues and had a responsibility to ensure that the residents' care needs were met.

The panel determined that there was sufficient evidence to indicate that residents' care needs were not being met.

The panel therefore found this charge proved.

Charge 1h)

h) Effective systems **were** in place to ensure residents' health and safety;

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witnesses 1, 2, 3 and 4. The panel saw a range of corroborative and contemporaneous evidence and exhibits which it considered alongside the oral evidence. The panel also took into account both your evidence and the evidence of Witness 5.

The panel had regard to Witness 1's statement:

'During the inspection we also found that the Providers, who included the Nurse, had not properly mitigated the risks associated with falls, or near misses, to service users. I was provided with the Home's accident and incident logs for June and October 2019, attach as Exhibit "MC20", by the Nominated Individual, which showed five recorded accidents/incidents in each month. However, the logs did not explain what they were or what actions had been taken to mitigate the risk of the same accident or incident happening again. Although the Nurse, or other Providers, did not personally complete the accident and incident logs, they failed to put an effective system in place to ensure that accidents and incidents were effectively recorded and investigated so that further risks could be identified and care plans/risk assessments were up to date.

[…]

We found that there was a significant fire risk, which had not been mitigated following an earlier fire inspection in February 2019. I was made aware of this fire inspection when reviewing [the fire officer's] *records from the inspection, as they took images of the completed fire inspection which identified the same concerns as we found.'*

The panel had sight of Witness 2's statement where she stated:

"[…] the fire service informed us by telephone that they were considering serving an Enforcement Notice on the Home regarding a breach of fire regulations. […] the concerns they had identified were that: fire procedures were conflicting, fire doors were locked at night, keys were left in fire doors, there were no trained fire wardens and the maintenance of fire extinguishers was inconsistent and incompetent.

[…]

[…] *I also found an empty bottle of prescription methadone and a number of tablets with the residents' possessions. This was a concern as these medications were not safely stored. When I asked them about this, they told me that they did not have access to medications and did not self-administer, meaning that they relied on staff to administer medications.*

[…]

The resident's room also smelt of cigarettes and there were many cigarette burns on the floor and mattress."

"Further to finding out this information I advised the Section 117 Team of the developments and they informed me that they were actively looking for new placements for the residents they were responsible for, which encompassed all of the CCG funded residents at the Home, due to the concerns. I also contacted Portsmouth Hospital to advise that they should not discharge any patients originating from the Home back to the Home. This is an action we take when we have serious concerns about the safety of residents within a service.

…

I advised the Manager, [PRIVATE], that as there were residents who were considered fall risks, the lack of lighting was leading to enhanced risk and that they should review staffing support in those areas of the building with limited light. I also observed that some of the residents' rooms only had table lamps as their ceiling lights were not working.

I observed use of personal protective equipment, but there were no clinical waste facilities. As the Home was registered as a residential home, such facilities are not required, however, as residents were soiling clothes and pads, and personal protective equipment was being used, I felt it was necessary to have these facilities in place. It was not clear how soiled clothes, pads and used personal protective equipment were being dealt with."

The panel also took into account Witness 3's statement:

> *"The management of oxygen in a care home presents a number of risks. In particular, the risk of fire with regards to the storage and administration of the oxygen is significant. In the Home residents were able to smoke in their rooms which heightened the fire hazard* […]*"*

The panel had regard to Witness 4's statement:

> *"I was aware of fire risks at the Home as there were no Personal Emergency Evacuation Plans for residents and doors were often left locked."*

In Witness 4's oral evidence, the panel heard that the last fire evacuation drill had been recorded as taking place in March 2016. He confirmed that no fire drills had taken place during his time as manager of the Home.

The panel had sight of the CQC inspection report in December 2019, which highlighted that portable heaters in the lounge had no risk assessments in place and also electrical sockets were overloaded in the office. Both of these issues had previously been highlighted in the fire inspection report in February 2019 and no action had been taken to address either issue.

The panel took account of the NMC witness statements and found their evidence was supported by the photographic evidence showing her fully loaded electrical sockets with multiple extensions and cables. The panel considered the Home had not provided reports setting out any actions taken to reduce health and safety risk. The panel determined that effective systems were not put in place to ensure residents' health and safety were maintained.

The panel noted you accepted that you overloaded electrical sockets that posed a fire hazard and health and safety risks and Witness 5 had not previously encountered this

issue. You told the panel that Witness 5 considered these issues around fire drills were being dealt with by administrator for the Home.

The panel considered that as a registered nurse and a director who regularly visited the Home, you should have been alert to these issues and had a responsibility to ensure residents' health and safety.

The panel therefore found this charge proved.

Charge 1i)

> i) Effective systems were in place to safeguard service users from abuse and/or improper treatment.

This charge is found proved.

In reaching this decision, the panel took into account the independent evidence of Witness 1. The panel saw a range of corroborative and contemporaneous evidence and exhibits which it considered alongside the oral evidence. The panel also took into account both your evidence and the evidence of Witness 5.

The panel noted Witness 1's statement where she stated:

> *"We found that service users were not protected from abuse and improper treatment and service users were placed at risk of institutional abuse and neglect. For example, during the inspection we found that, as explained above, service users could not access food when required because the Providers had implemented restrictions on the access of food to both staff and service users."*

The panel also considered the following in Witness 1's statement:

“The Providers had failed to ensure that staff had completed training in safeguarding adults from abuse. Staff were unable to demonstrate how to recognise abuse and the action to take if they had concerns.”

The panel had regard to the CQC’s report findings on staff training where it was documented that four care staff did not have up-to-date training in safeguarding. The panel heard from Witness 1 that the residents could be subject to institutional abuse, for example, lack of sufficient access to food.

The panel determined that the witnesses’ evidence corroborates and is supported by the documentary evidence.

The panel considered that as a registered nurse and a director who regularly visited the Home, you should have been alert to these issues and had a responsibility to act in relation to residents’ safeguarding from abuse and improper treatment.

The panel therefore finds this charge proved.

Conclusion

The panel noted the evidence provided by both you and Witness 5 in relation to issues of bias and discrimination. The panel having heard the evidence from the NMC witnesses and noting the supporting documentary evidence did not feel that bias and discrimination played any part in relation to the findings of fact outlined in this determination.

The panel would also add that, overall, it accepts that for long periods of time (up to at least September 2019, and beyond) the Home was being run and administered appropriately and that the above failings arose mainly during a period of three to four months from September 2019 to December 2019.

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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

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

Ms McGuiness identified the specific, relevant standards where your actions amounted to misconduct. She submitted that your conduct fell significantly short of the standards expected of a registered nurse when you were a Director at BSR London Limited and which owned and ran Chesterholme Lodge. Ms McGuiness submitted that you failed to adequately safeguard residents in that you did not ensure that there were [sufficient] numbers of suitably qualified staff to meet the needs of residents (service users), that staff had received appropriate training, that the Mental Capacity Act 2005 was understood and/or applied by staff, that resident's privacy and dignity was promoted; that residents were provided with a clean and hygienic environment; that their nutritional needs were

met, that that care needs were assessed and met; that effective systems were in place to ensure residents' health and safety and that effective systems were in place to safeguard residents/service users from abuse and/or improper treatment.

Ms McGuiness submitted that the panel should also consider whether your conduct did fall significantly short of the standards and amounted to multiple breaches of the Code. She referred the panel to multiple breaches of the Code.

Ms McGuiness submitted that the misconduct in this case is sufficiently serious and that it can be properly described as misconduct both individually and cumulatively. In all the circumstances, she submitted that the panel should consider that your conduct falls far below the standards which would be considered acceptable and that the facts found proved amount to misconduct.

You submitted that you came to England in 1995 with the ambition of working in the care industry. You said you started working as a care assistant before qualifying as a nurse. You said that whilst you were studying for your nursing degree, you were working part-time as a care assistant in a care home, taking care of your 6-year-old son and making a home for your family.

You submitted that despite the struggles and hardships you faced, you are very proud of your achievements and had goals to help people in the hospital and community. You said you always had a good character and a work ethic and that you have never had any problems with your duty of care in all your years of work. You said that you have never had any complaints about your duty neither any misconduct. You said that you worked during the Covid-19 pandemic in the Hospital as a bank nurse when they were short of nurses due to illnesses and people not wanting to risk their lives. You said you saw it as your duty to work despite both your husband and son not wanting you to.

You said you have always tried your best to be kind, professional, and deliver your duty safely. You said you are still working in the care industry and that you carry that ethos with

you. You said you always made sure your service is safe and does not pose any risks to any residents and staff. You submitted that the Quality Monitoring officer from Norfolk County Council praised your care service, your staff and you for upholding good care practices.

You said you can only apologise for the past and not knowing that you held a responsibility and a duty of care with a directorship. You said you should have stepped in a lot earlier and been involved from the beginning. You said the only thing you can do is apologise and learn from your mistakes going forward.

Submissions on impairment

Ms McGuiness 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. Ms McGuiness referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms McGuiness submitted that limbs a, b and c in the case of Grant are engaged. She submitted that you have acted in the past and/or are liable so as to put patients at unwarranted risk of harm. She submitted that you placed patients at unwarranted risk of harm when there were not enough staff members and staff members did not have the time required to provide residents/service users with responsive and effective care in line with their specific needs and requirements or that staff in post had the required skills and knowledge.

Ms McGuiness submitted that you failed to ensure staff had completed training in supporting residents'/'service users' specific needs, which meant that these needs were not always supported safely which would have a negative impact on residents/service users. Ms McGuiness submitted that, by failing to provide adequate food and fluid as the

food budget was restricted, resident's health needs would not be met, with a risk of malnutrition being highlighted when a resident lost weight. She submitted there was a risk of harm when medication was administered by staff who did not have adequate training, and a risk associated with medication errors having a detrimental impact to residents'/'service users' physical and mental health.

Ms McGuiness submitted that the panel should consider that unwarranted risk of harm to residents/service users arose in relation to risk of fire and danger due to the environment of the Home, the lack of personal [evacuation] plans and failure to carry out fire drills.

Ms McGuiness submitted that the panel should also consider the potential for harm to:

- Service User A who suffered from diabetes having experienced poor insulin management;
- Service User B, due to poor management of oxygen administration and storage;
- Service User C, due improper monitoring of codeine patch administration;
- Service User D, due to poor management of medication for a mental health condition;
- Service User E, due to a lack of care planning for the complications of epilepsy.

Ms McGuiness submitted that your conduct also placed residents/service users at unwarranted risk of harm in relation to failures to assess residents' care needs (as previously set out).

Ms McGuiness submitted that that residents/service users were placed at an unwarranted risk of harm when Mrs Ramana failed to identify the environmental risks in relation to the poor condition of bedroom 9, which could have had an impact upon the health of anyone within the home and increase fire risk. She submitted that residents/service users were placed at risk of institutional abuse and neglect due to food being restricted and further failure to ensure staff had completed training in safeguarding adults from abuse,

potentially resulting in staff being unable to demonstrate how to recognise abuse and take action.

Ms McGuiness submitted that residents/service users were placed at risk of physical, but also emotional/psychological harm, where their dignity and privacy were not respected. She submitted that there was an unwarranted risk of harm and a potential for serious harm.

Ms McGuiness submitted that the panel should consider that 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 loved one's lives. Ms McGuiness submitted that when considering the risk of harm to patients, the panel should consider the possible consequences of the concerns, such as members of the public feeling reluctant to access health and care services.

Ms McGuiness submitted that such behaviour not only brought your reputation into disrepute, but also that of the wider profession. Ms McGuiness submitted that this undermined the public's confidence in the profession as a whole. She submitted that the public expect nurses to adequately safeguard residents/service users and to ensure: sufficient numbers of suitably qualified staff are there to meet the service user's needs; staff had received appropriate training; the Mental Capacity Act 2005 was understood and/or applied by staff; residents' privacy and dignity was promoted; residents were provided with a clean and hygienic environment; their nutritional needs were met and care needs were assessed and/or met and that effective systems were in place to ensure residents' health and safety and to safeguard service users from abuse and/or improper treatment. Ms McGuiness submitted that the facts, as set out in the charges, brought the profession into disrepute and had the potential to undermine trust and confidence in the profession. She submitted that confidence in the profession would be undermined if its regulator took no action.

During clarification questions from the panel, you responded that you registered to work in an NHS Hospital in 2020 when the hospital had a shortage of staff. You said that you worked during the pandemic and in your own care home as well. You said that you were working there during Monday to Friday and then on the hospital bank at weekends on your days off. [PRIVATE].

You said that, upon reflection you have acknowledged that, no matter what capacity you are involved in, whether it be within a company or establishment, you will always make sure to get involved and carry out your duties as a nurse. You said that you undertook ongoing training and that you did not stop doing your training. You said that you will not find yourself in this situation in the future and that you will be more involved in any company you are attached to. You said that you will provide the duty of care as a nurse as you have throughout your entire career.

You said that you have had a lot of time to reflect and that you regret your lack of involvement with the Home from the beginning. You said you have spent your time working and providing care to others. You said that it affects you if any resident did not have the appropriate care needed. You said that you try hard to have a nurturing and caring environment and that you can only apologise and promise that you have learnt from this.

In response to the panel's questions, you said that you took all precautions (at Coralyn House) to carry out robust infection prevention and control in order to protect your own residents. You said that you were always checking their health, especially if residents were seen to be feeling unwell, you would check their blood pressure and their oxygen levels.

You said that you are a mental health nurse and that during the pandemic, you worked additional shifts on the nurse bank, whenever there was a patient who needed monitoring, you observed mental health patients in the wards.

Finally, you gave the panel details of training courses you have attended since the closure of the Home. The panel noted that they were all “online” courses.

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> ***1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.5 respect and uphold people’s human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> *2.1 work in partnership with people to make sure you deliver care effectively.*
> *2.2 recognise and respect the contribution that people can make to their own health and wellbeing.*
> *2.3 encourage and empower people to share in decisions about their treatment and care.*

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.

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it.

4 Act in the best interests of people at all times

To achieve this, you must:

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process.

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively

To achieve this, you must:

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.

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions.

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse.

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

In reaching its decision on whether your actions amounted to misconduct, the panel took into account the advice of the legal assessor, who reminded the panel that your actions had to fall, not just short, but far short, of the standards expected of a registered nurse. It further noted the suggestion that, to amount to misconduct, fellow professionals would find your failings "deplorable."

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.'*

The panel reminded itself that, in reality, you faced just one charge, namely that you "failed to adequately safeguard residents" in that you did not ensure that those residents were provided with adequate care in relation to the matters set out in sub paragraphs (a) and (i).

The panel considered that your failing "to adequately safeguard residents", many of whom were vulnerable, by itself is sufficiently serious so as to amount to misconduct, since safeguarding patients or residents is a fundamental and basic requirement of nursing.

However, notwithstanding that overall finding, the panel went on to consider whether each of the matters specified in sub paragraphs (a) to (i) individually amount to misconduct. The panel has found that they do.

In relation to sub paragraph (a), the panel considers that failing to ensure that there were sufficient numbers of qualified staff available to meet service users' needs was serious on the basis that the lack of such staff would inevitably endanger service users, especially if an emergency arose with one service user whilst staff were otherwise engaged. The panel noted that you accepted that two care staff managing 15 residents was inappropriate.

In relation to subparagraph (b), the panel considers that failing to ensure that staff were appropriately trained was serious on the basis that a lack of appropriately trained staff would, once again, inevitably endanger service users (especially if there were insufficient staff to begin with) in particular if an emergency arose.

In relation to subparagraph (c), the panel considers that not ensuring that the Mental Capacity Act 2005 (which was in any event part of your specialisation as a mental health nurse) was understood and applied by staff, was serious on the basis that there was potential for service users' needs to be overlooked, thereby potentially causing them distress (for instance, when a resident could not access his money due to his bank card being locked away) or to be placed at risk, (for instance, where doors were left unsecured and those deemed lacking in capacity were able to leave the Home unattended) at a time when they were entitled to expect that they were in a safe and caring environment.

In relation to subparagraph (d), the panel considers that not ensuring residents' privacy and dignity was promoted to be serious. This is on the basis that there was potential for service users to become distressed (for instance, due to anxiety about outsiders being able to look into their private rooms, or because of noxious smells in the Home) at a time when they were entitled to expect that they were in a safe and caring environment.

In relation to subparagraph (e), the panel considers that failing to provide a clean and hygienic environment was serious on the basis that there was a potential for residents both to become distressed at the lack of cleanliness and for their health to suffer because of the lack of hygiene, at a time when they were entitled to expect that they were in a safe and caring environment.

In relation to subparagraph (f), the panel considers that failing to meet residents' nutritional needs was serious on the basis that a lack of nutrition would clearly adversely affect residents at a time when they were entitled to expect they were in a safe and caring environment.

In relation to subparagraph (g), the panel considers that failing to assess and meet residents' care needs is serious on the basis that caring for residents is a fundamental and basic nursing duty. As residents of the Home, service users were entitled to expect that they were in a safe and caring environment.

In relation to subparagraph (h), the panel considers that failing to have effective systems in place to ensure residents' health and safety, was particularly serious on the basis that the lack of review systems regarding the risk of residents' injury. In relation to potential breaches of the Fire Regulations, clearly put residents at risk of serious harm at a time when they were entitled to expect that they were in a safe and caring environment.

In relation to subparagraph (i), the panel considered that the lack of systems to safeguard service users from abuse and improper treatment was serious on the basis that there was the potential for service users to become subject to abuse and improper treatment at a time when they were entitled to expect that they were in a safe and caring environment.

The panel therefore concluded that the specific failings with regard to subparagraphs (a) to (i) were individually and collectively serious enough to amount to misconduct, in addition to its earlier finding that a failure to safeguard residents by itself already amounted to misconduct. The panel consider the findings in this case relate to failures across a wide spectrum of fundamental nursing care.

The panel has taken account of the fact that your failings came to light in the period from the end of September 2019 to the end of December 2019. However, that does not, in the panel's view, detract from the seriousness of the misconduct, for the reasons already outlined.

The panel further noted that some of the subparagraphs related to duties imposed upon you by you becoming a Director of BSR London Limited (in particular subparagraphs (a), (b), (c), (h) and (i)), about which duties you indicated a lack of knowledge at the time. However, the panel has already rejected that defence and, moreover, considers that, knowing that Witness 5, your son, did not have the necessary skills to run the Home without a Manager, you should have immediately become more involved when you discovered that the Home's Manager had left at the end of September. The panel considered that you would have had some awareness of such responsibilities as you were running your own separate residential home and, in addition, the panel noted that you had personal knowledge of the facts that there were insufficient staff at the Home and that there were concerns about the residents health and safety (which the panel, in any event, considers overlapped with your duties as a nurse to comply with the Code).

The panel also considered that the remaining subparagraphs were duties imposed upon you as a nurse under the Code, in particular subparagraphs (d), (e), (f), and (g), all of which involved the provision of fundamental and basic nursing care, and which were in your own knowledge as a regular visitor to the Home.

In assessing the seriousness of your actions overall, the panel has also taken into account the fact that concerns were raised by a number of fellow professionals in addition to staff at the Home. Those professionals included a care coordinator, safeguarding specialist nurses, social work staff and a GP. The nursing team were *"shocked"* and found it *"challenging to accept"*, when discovering that a nurse was one of the Home Directors. In the panels' view, this emphasises the seriousness of your failings since others were clearly aware of the conditions at the Home when you apparently were not.

Finally, the panel considers that, leaving aside the overall failing to adequately safeguard residents, a further factor aggravating the seriousness of your failings is the apparent abdication of responsibility for the observable failings at the Home. You did not appear to attempt to acquaint yourself with what your responsibilities would be as a Director of BSR London Limited before taking on that role and, in addition, because you took no action to

rectify them, you appeared to ignore a number of issues at the Home notwithstanding being aware of your duties as a nurse under the Code.

Taking all these matters into account, the panel concludes that all elements of the charge found proved individually and collectively amount to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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*

The panel finds that residents were put at risk of physical, psychological and emotional harm as a result of your misconduct. Your misconduct also breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to misconduct found in this case, serious.

Regarding insight, the panel considered that your insight is limited and that you did not appreciate the impact of your misconduct on residents and on the wider public interest. The panel took into account the testimonials that were provided to them from your previous deputy manager and a colleague but considered that the testimonials did not speak to your current practice. The panel also took into account that, although you have shown some insight into your failings and that you have apologised, it has not seen any evidence of any meaningful reflection addressing the wider issues in this case. The panel considered that you have blamed others instead of putting effective strategies in place as the Director of the Home. The panel further noted that, whilst the issues in the charges are remediable, there is no evidence that you have fully remediated your misconduct in any practical sense.

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 you have taken steps to strengthen your practice. The panel considered that you were unable to set out what actions you would take in the future to reduce the risk of repetition in relation to your clinical practice. The panel considered that you lack awareness of the issues raised, even at this late stage of the fitness to practise process.

The panel noted that you have provided limited documents and examples of training and learning that you have completed. In particular, the panel noted that all of the courses were online with no evidence of assessment. The panel noted that some of the courses related to the matters charged; however, you have not provided any reflections about the courses, what you have learned from them and how you intended to apply that learning to your current practice.

The panel determined that you were unable to demonstrate or acknowledge the potential harm or risk to residents (services users) caused by your misconduct.

The panel took into account that, whilst you have expressed that you are sorry and that you now recognise your duties, your focus was on the impact on yourself rather than the impact on residents/service users, many of whom were vulnerable, their families, staff in the home, the wider public and the impact on the profession and public confidence. The panel consequently determined that there is a real risk of repetition of the conduct in the charges found proved.

The panel bore in mind 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 therefore determined that, especially as the misconduct has not been remediated, a finding of current impairment needs to be made in order to sufficiently protect the public. The panel therefore find your fitness to practise currently impaired by reason of your misconduct on public protection grounds.

The panel further took into account that a well-informed member of the public would be concerned if the panel did not make a finding of impairment, given the seriousness and nature of the charges and the serious failings in this case. The concerns are of such a serious nature that the wider public interest requires a finding of impairment to uphold the standards of the profession, maintain confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession and the NMC would be undermined.

Having regard to all of the above, the panel was also satisfied that your fitness to practise is currently impaired on public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of twelve months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Submissions on sanction

The panel took into account the written submissions of both parties, which it has summarised below.

Ms McGuiness informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired. During the course of the hearing, the NMC reiterated its proposal and submitted that a striking-off order was appropriate in light of the panel's findings.

Ms McGuiness submitted that the NMC considered a striking-off order as the most appropriate and proportionate sanction. Ms McGuiness set out the NMC's view on the aggravating and mitigating features in this case.

Ms McGuiness reminded the panel that you were found impaired on both public protection and public interest grounds and that there remains a risk of repetition and a risk of harm to patients. She went on to set out the available sanctions and submitted that: taking no action or imposing a caution order were not appropriate since there would be no restrictions on your practice; imposing a conditions of practice order or a suspension order were not appropriate because they did not reflect the seriousness of your misconduct, and therefore a striking off order was the only appropriate sanction as your misconduct was, in the NMC's view, fundamentally incompatible with you remaining on the register.

You submitted that you fully accepted responsibility for your actions and inactions and acknowledged the impact your misconduct has had on residents, the wider public and the nursing profession as a whole. You said that it saddens you that you fell short of fulfilling your duty as a nurse. You submitted that you made the mistake of distancing yourself from these responsibilities due to the fact that the nominated individual at the Home was your son.

You submitted that you are committed to enhancing your understanding in this area and others highlighted by the panel as deficient. You said that you are eager to undertake further in person training and would welcome recommendations for suitable courses. You said that a lot of your training was online and that this was particularly because of the COVID-19 pandemic. You said that you sent your sincere apologies for your actions to the residents and their families.

You asked the panel not to strike you off the register. You said that you had demonstrated your nursing skills for several years without any regulatory concerns and that you had effectively managed your home at Coralyn House since 2010 without any issues. You said that you have received significant positive feedback and that the Care Professional County Commissioners, family members and visitors have all commented positively about your management and leadership.

You said that you have continued to work in the care sector without any issues, even during the challenging COVID-19 period where you volunteered as a nurse to support frontline staff in hospitals. You said that this demonstrated your ongoing fitness to practise.

You maintained that, given the isolated nature of the incident, taking no further action is appropriate and would allow you the opportunity to demonstrate your commitment to the profession. You said that you want to continue being a nurse and that you would like to help wherever it is needed.

You said that you currently look after residents at Coralyn House and that you apply your nursing skills if any residents become unwell. You said that you respond quickly to anyone having a problem as you are a manager at the Home. You said that you have a good knowledge of your role as a nurse.

Prior to delivering your submissions, you provided the panel with a number of new documents. These included two Provider Assessment and Market Management Solution (PAMMS) reports for Coralyn House, from 2022 and 2023. These reports document visits undertaken by the local council to assess the quality of care delivered by the home.

You also submitted a selection of the Coralyn House feedback forms which had positive comments, from a variety of sources including health and social care professionals and residents' families.

The panel considered these were relevant and they provided up to date evidence relating to your current practice as a residential home manager and provider.

The panel determined it was fair to allow these documents to be submitted after your case on impairment was closed, as you were not legally represented, therefore, were not familiar with the running of a Fitness to Practise hearing. There were no objections to them being included from Ms McGuiness.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Vulnerable service users were put at risk of harm (albeit that your misconduct was by omission and not by commission)
- You were in a position of trust and responsibility
- Pattern of misconduct over a sustained period of time, 3 months
- Lack of remediation
- Wide ranging concerns
- Abdication of responsibility

The panel also took into account the following mitigating features:

- Co-proprietor of the Home (with your son, especially, not wanting you to become involved)

- Making admissions at the outset of this hearing, to failing in your duty to safeguard residents as a Director of the Home
- Evidence of some training
- Expressed remorse and apologised
- No repetition of your misconduct for 4½ years since the period in question

In respect of insight, the panel considered the new information about your recent practice, alongside your submissions on sanction, expressing some appreciation of how your misconduct affected the wider public, fellow nurses, and the reputation of the profession, and asserting your willingness to strengthen your practice.

The PAMMS reports contained references to the kindness of staff, and the homely atmosphere at Coralyn House, under your management. Although these reports evidence some areas in need of improvement including safeguarding, staff awareness of the Mental Capacity Act, and health and safety issues, these appear to have been improved between the reports, and both reports have an overall rating of 'good'. Taking all these factors into consideration the panel consider you have now been able to demonstrate emerging insight, albeit at a late stage of the Fitness to Practise process.

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 or in the public interest to take no further action nor would it provide public protection.

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 your 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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate

in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, however, the panel is of the view that there are no practical or workable conditions that could currently be formulated, given the nature of the charges in this case, the wide-ranging issues in your practice and your current limited level of insight. The panel considered that, to properly address your failings, the conditions would likely have to be so restrictive that they would be tantamount to suspension. Furthermore, the panel concluded that the placing of conditions upon your practice would not adequately address the seriousness of this case particularly with regard to the public interest.

The panel therefore concluded that the ultimate choice in sanction in your case was whether to suspend you from practice, or whether to strike you from the register.

It first considered a suspension order. The panel noted the factors set out in the SG and concluded that the seriousness of the case justified your temporary removal from the register and a suspension order would be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, and would serve to uphold professional standards.

The panel took into account and found that, although it could not be said that this was a single instance of misconduct, the events which led to the charges took place during a relatively short period of time (3 to 4 months) in the three years or more during which the Home was operational; there was no evidence of harmful deep-seated personality or attitudinal problems and no evidence of repetition of behaviour since the incident.

The panel determined that the issues arose when you failed to understand that as a Director and a registered nurse, you had a duty to actively participate in the running of the

Home. Due to your other commitments at Coralyn House, the evidence from your son and husband, was that they were able to run the Home without your involvement.

The panel also recognised that you have taken some steps to strengthen your nursing practice through completing various training courses in the areas of concern. Consequently, the panel was satisfied that the misconduct in this case, being remediable and essentially arising out of your failure to manage the situation, was not fundamentally incompatible with you remaining on the register.

The panel seriously considered the imposition of a striking-off order in this case, and in doing so, considered the following paragraphs of the SG with respect to imposing a striking-off order:

- *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?*

However, taking account of all the evidence before it, namely: that you have an unblemished nursing career, there have been no further incidents since 2019; the limited steps you have taken to strengthen your nursing practice; and the positive testimonials on your behalf, the panel concluded that a striking-off order would be disproportionate and, arguably, punitive.

The panel took into account your submissions on your nursing practice and present circumstances and was not satisfied that a striking-off order was the only sanction sufficient to protect the public and to address the public interest considerations in this case.

The panel considered that a fully informed member of the public, taking the context and all of the circumstances surrounding this case into account, would consider that a period of suspension would adequately address the public interest aspect raised in this case.

Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive in this case to impose a striking-off order at this stage. It was of the view that a striking-off order could deprive the public of a registered nurse who has the potential to return to safe nursing practice in the future. Therefore, a striking-off order would not serve the public interest considerations in this case.

Balancing all of these factors, the panel concluded that a suspension order would be the appropriate and proportionate sanction to protect the public and address the public interest in this case. It was satisfied that a suspension order for a period of twelve months was necessary to mark the degree of seriousness found in relation to your misconduct. The panel considered that this suspension would provide you with an opportunity to strengthen your practice and develop sufficient insight into your misconduct so as to show that your fitness to practise is no longer impaired.

The panel determined that this order is necessary to protect the public, mark the seriousness of the misconduct, maintain public confidence in the profession, and send to the public and to the profession, a clear message about the standard of behaviour required of a registered nurse.

The panel noted the hardship such an order may cause; however, this is outweighed by the public interest in this case.

The panel decided that a review of this order should be held before the end of the period of the suspension order.

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

Any future panel reviewing this case would be assisted by:

- Continued engagement with, and attendance at the NMC review hearing
- Any evidence of reflection addressing the specific concerns raised in this case, including those itemised in the sub-paragraphs of the charge
- Evidence of learning from any training you have undertaken, which relates to the charges found proved and in particular, how you have strengthened your practice
- Evidence of any self-directed learning
- Up-to-date testimonials or references speaking to your current practice

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interest until the suspension order 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 McGuiness. She submitted that an interim suspension order for a period of 18 months is necessary to protect the public and is otherwise in the public interest.

Mr Ramana, on your behalf, submitted that you have worked really hard to obtain your PIN, that you have learnt from this order and will not repeat this again in the future. He stated that it is a regret that you will carry for the rest of your life. Mr Ramana submitted that you carried out your duties in the Hospital during the pandemic, that you have carried out your duties and that you have since then successfully worked in the care industry as a registered manager.

Mr Ramana submitted that everyone is prone to making mistakes and that on this occasion, it is an anomaly. He submitted that an interim suspension order is not appropriate in this case.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow sufficient time for any appeal to be heard. The panel is satisfied that such an order is appropriate and proportionate in the circumstances of this case and that not to make such an order would be entirely contradictory to the panel's substantive decision in this case.

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

That concludes this determination.