Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 7 November – Friday 11 November 2022
Monday 21 November – Tuesday 22 November 2022
Tuesday 26 September – Thursday 28 September 2023

Virtual Hearing

Name of registrant:	**Binoy John**
NMC PIN:	11D0004O
Part(s) of the register:	Registered Nurse RN1**:** Adult Nurse (4 April 2011)
Relevant Location:	Nottinghamshire
Type of case:	Misconduct
Panel members:	Tanveer Rakhim (Chair, Lay member) Carol Porteous (Registrant member) Asmita Naik (Lay member)
Legal Assessor:	John Bassett
Hearings Coordinator:	Amira Ahmed (7 November 2022) Nandita Khan Nitol (8-11 November 2022) Sophie Cubillo-Barsi (21-22 November 2022) Jennifer Morrison (26-28 September 2023)
Nursing and Midwifery Council:	Represented by Louise Cockburn, Case Presenter
Mr John:	Present and represented by Laura Bayley, instructed by the Royal College of Nursing (RCN).
Facts proved by admission:	Charges 2, 5, 6, 9(b), 9(e), 10, 11
Facts proved:	Charges 1, 7, 8(b) and 9(a) in relation to limbs (ii) and (iv) only
Facts not proved:	Charges 3, 4, 8(a), 8(c), 9(a)(i), 9(a)(iii), 9(c), 9(d)

Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order (9 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Bayley, on behalf of you, to amend the wording of charge number 10.

It was submitted by Ms Bayley that the proposed amendment would provide clarity and more accurately reflect the evidence.

Ms Cockburn, on behalf of the Nursing and Midwifery Council (NMC), did not oppose to the application for the proposed amendment.

Later in the hearing, following the refusal of Ms Bayley's application for no case to answer in relation to charge 11(b), the panel on its own volition proposed to amend the charge 11(b) by including the word 'adequately' and excluding the words 'and/or escalate' to reflect the evidence more accurately.

Ms Cockburn and Ms Bayley supported the proposed amendments by the panel.

Original charges:

> *'That you, a Registered Nurse, whilst employed as the Home Manager at Maun View Care Home ("the Home) between 8 April 2019 and 29 July 2019 did not ensure an adequate standard of care was provided to residents at the Home, as identified by the CQC following unannounced inspections in May and July 2019, in that you:*
>
> *10) Did not prepare for and prioritise patient safety during a forecasted heatwave on 25 July 2019 in that:*
>
> *a) Not all residents had access to a fan.*
>
> *b) One or more of the resident's rooms were not ventilated*
>
> *c) Adequate steps were not taken to mitigate dehydration and/or heat exhaustion*

11) *Did not ensure staff followed the Home's policies in relation to Residents' falls in that you:*

a) *Did not ensure Residents were referred to the community falls team.*

b) *Did not action and/or escalate unexplained injuries.*

c) *Did not make safeguarding referrals without delay or at all.'*

Proposed charges:

'That you, a Registered Nurse, whilst employed as the Home Manager at Maun View Care Home ("the Home) between 8 April 2019 and 29 July 2019 did not ensure an adequate standard of care was provided to residents at the Home, as identified by the CQC following unannounced inspections in May and July 2019, in that you:

10) Did not ***adequately*** *prepare for and prioritise patient safety during a forecasted heatwave on 25 July 2019 in that:*

a) Not all residents had access to a fan.

b) One or more of the resident's rooms were not ventilated

c) Adequate steps were not taken to mitigate dehydration and/or heat exhaustion

11) *Did not ensure staff followed the Home's policies in relation to Residents' falls in that you:*

a) *Did not ensure Residents were referred to the community falls team.*

b) *Did not* ***adequately*** *action* ~~*and/or escalate*~~ *unexplained injuries.*

c) *Did not make safeguarding referrals without delay or at all.'*

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

The panel was of the view that the amendment in the wording of the charges, as applied for, was in the interest of justice. The panel noted that the word adequately was reflected in charge 10(c). Therefore, 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. Further, the panel determined that it would be in the public interest to allow the proposed amendment to Charge 10, as applied for, and Charge 11(b), to ensure clarity and accuracy.

Details of charge (as amended)

'That you, a Registered Nurse, whilst employed as the Home Manager at Maun View Care Home ('the Home') between 8 April 2019 and 29 July 2019 did not ensure an adequate standard of care was provided to residents at the Home, as identified by the CQC following unannounced inspections in May and July 2019, in that you:

1. *Did not ensure that you/staff completed care plans to reflect Residents' needs.* ***[PROVED]***

2. *Did not ensure that you/staff completed risk assessments* ***[PROVED IN ITS ENTIRETY BY WAY OF ADMISSION]***
    a) *To reflect Residents' needs; and/or*
    b) *That adequately mitigated risk.*

3. *Did not ensure that staffing levels were appropriate for the number of residents in the Home.* ***[NOT PROVED]***

4. *Did not ensure staff were deployed based on adequate/required skill sets.* ***[NOT PROVED]***

5. *Did not ensure staff had adequate knowledge of service users.* ***[PROVED BY WAY OF ADMISSION]***

6. *Did not effectively supervise staff members.* ***[PROVED BY WAY OF ADMISSION]***

7. *Did not ensure there was adequate and/or safe handover systems in place.* ***[PROVED]***

8. *Did not ensure Residents' nutritional and hydration needs were consistently and sufficiently:*
    a) *Assessed; and/or* ***[NOT PROVED]***
    b) *Monitored; and/or* ***[PROVED]***
    c) *Reviewed.* ***[NOT PROVED]***

9. *Did not ensure medications were safely and/or effectively managed in that:*
    a) *Medication was not consistently;*
        i) *ordered;* ***[NOT PROVED]***
        ii) *stored;* ***[PROVED]***
        iii) *administered;* ***[NOT PROVED]***
        iv) *disposed of.* ***[PROVED]***
    b) *More than one Resident's medicine profiles had not been fully completed.* ***[PROVED BY WAY OF ADMISSION]***
    c) *Resident 1's prescribed medication was stored without a pharmacy label and instead had a handwritten label with no administration details.* ***[NOT PROVED]***
    d) *Instructions on the method of administration of medication were not always documented.* ***[NOT PROVED]***
    e) *In relation to Resident 2 did not ensure their medication was assessed by a suitably qualified professional following 'end of life care' no longer being relevant.* ***[PROVED BY WAY OF ADMISSION]***

10. *Did not adequately prepare for and prioritise patient safety during a forecasted heatwave on 25 July 2019 in that:* ***[PROVED IN ITS ENTIRETY BY WAY OF ADMISSION]***
    a) *Not all residents had access to a fan.*
    b) *One or more of the resident's rooms were not ventilated*

c) *Adequate steps were not taken to mitigate dehydration and/or heat exhaustion*

11. *Did not ensure staff followed the Home's policies in relation to Residents' falls in that you:* ***[PROVED IN ITS ENTIRETY BY WAY OF ADMISSION]***
    a) *Did not ensure Residents were referred to the community falls team.*
    b) *Did not adequately action unexplained injuries.*
    c) *Did not make safeguarding referrals without delay or at all.*

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

Decision and reasons on application to admit further documents under Rule 31

Ms Cockburn applied under Rule 31 to allow into evidence the Case Management Form (CMF) dated 6 April 2021 and another document which is a letter from your instructing solicitor dated 15 January 2021.

Ms Cockburn submitted that the CMF consisted of all your admissions regarding the charges and the second document included the submissions from the RCN in regard to your response to the case examiner. She informed the panel that it was seen by the Case Examiners. Ms Cockburn submitted that it is for the panel to decide the relevance, fairness, and importance of this evidence.

With regards to the CMF, Ms Bayley did not object to parts of the document to the panel which included section 3 and the admissions you made along with the evidence matrix. However, she objected to the other parts of the document going to the panel.

With regards to the second document, Ms Bayley objected to the letter being presented to the panel as the communication was privileged.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel was of the view that, with regards to the CMF dated 6 April 2021, the whole document should be admitted, and the panel would consider matters involving your admissions. The panel is a professional body and well able to ignore anything that was not relevant at that stage.

Furthermore, with regards to the second document dated 15 January 2021, having been sent to the NMC on your behalf by your solicitors having taken your instructions, no issue of privilege arose. The content was relevant and not prejudicial to you as there was useful information to determine the weight of the evidence presented to the panel.

The panel was of the view that the evidence was not unfair to you nor the NMC. Therefore, the panel determined that it was relevant and fair to admit the documents into evidence.

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

Prior to the oral evidence of the Witness 2, Ms Cockburn made a request that parts of this case be held in private in order to address the panel on a document with regards to Witness 2's personal matters. The application was made pursuant to Rule 19.

Ms Bayley did not oppose this application.

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

The panel determined to go into private session in connection with any matters related to the document regarding Witness 2 as and when such issues are raised in order to protect her privacy.

Decision and reasons on application of no case to answer

The panel considered an application from Ms Bayley that there is no case to answer in respect of charge 11(b). This application was made under Rule 24(7).

In relation to this application, Ms Bayley provided written submission which stated that:

1. *The Nursing and Midwifery Council ("NMC") brings this case and the burden of proof rests with the NMC at all times. Mr John is not required to prove anything. At the close of the NMC's case, it is submitted that the NMC has failed to discharge the persuasive and evidential burden and that there is no case for Mr John to answer in relation to charge 11b:*

   "11) Did not ensure staff followed the Home's policies in relation to Residents' falls in that you:
   ...
   b) Did not action and/or escalate unexplained injuries."

   <u>Legal Framework</u>

2. *Application in relation to the facts is made under Rule 24(7) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended:*
   "Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and - (i) either upon the application of the registrant, or (ii) of its own volition, The Committee may hear submissions from the parties as to whether sufficient evidence has

been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer…"

3. *In accordance with the principles set out in the criminal case of R v Galbraith [1981] 1 W.L.R. 1039, when considering whether there is a case to answer, the Panel should first determine whether there is any evidence upon which a Panel could properly find the charges proved. Where there is none, the Panel should find no case to answer. Where there is some evidence presented, the Panel should consider the nature and strength of that evidence and decide whether it can properly be relied upon to find the facts proved. Evidence which is inherently weak and vague, or inconsistent with the remaining evidence in the case, ought not be relied upon.*

4. *Application is made that no reasonable panel, properly directed could find the above charges proved. This is a legal application related to the sufficiency of the evidence in this case. The panel must decide whether the allegation could be made out, not whether it would be made out, on the balance of probabilities, taking the NMC case at its highest. The panel is reminded of the principle in the case of Shippey [1988] Crim LR 767 that "'taking a prosecution case at its highest' did not mean picking out the plums and leaving the duff behind."*

5. *The standard of proof the NMC must meet is the balance of probabilities. Application is made that the evidence presented is insufficient to meet that standard. The balance of probabilities requires the panel to consider all the evidence in the case and decide where the balance of the evidence lies in relation to each charge. There is no evidential burden upon Mr John to prove that these charges are false.*

6. *In the case of Re H (Minors) [1996] AC 563 at 586, Lord Nicholls explained that the balance of probabilities standard is a flexible test:*

"The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not. When assessing the probabilities the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability... Built into the preponderance of probability standard is a generous degree of flexibility in respect of the seriousness of the allegation. Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established."

7. *To quote from Lord Hoffman, in Secretary of State for the Home Department v Rehman [2001] UKHL 47:*
   "It would need more cogent evidence to satisfy [a judge] that the creature seen walking in Regent's Park was more likely than not to have been a lioness than to be satisfied to the same standard of probability that it was an Alsatian."

8. *R (Dutta) v GMC [2020] EWHC 1974 (Admin) is an important reminder to tribunals about the proper approach to the assessment of evidence and factual findings. The High Court found that, when assessing evidence, a panel should begin with a consideration of the objective facts, as shown by contemporaneous documents. It was suggested that the best approach is to base factual findings on inferences drawn from documentary evidence and known or probable facts.*

Contemporary documents are always of the utmost importance. This is particularly relevant when the witnesses have given oral evidence concerning events occurring at least four and a half years ago. The witness evidence can be tested against those known or probable facts. The documentary evidence can be tested against the oral testimony of witnesses.

9. *Dutta also highlights that it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based in that recollection provides any reliable guide to the truth. The demeanour of a witness is not a reliable pointer to his or her honesty. It is an error of principle to ask "do we believe him/her?" before considering the documents. Particular regard should be had to the witnesses' motives and to the overall probabilities. Credibility can be supported by internal or external consistency of witness evidence.*

10. *The NMC produces guidance on "no case to answer" applications, as well as taking account of context.*

<u>Sufficiency of Evidence</u>

11. *It is unfortunate that the Panel does not have any patients' notes or policies. The issues with charge 11 have been raised. There is no evidence to demonstrate what was in the Home's policies about unexplained injuries. There is no evidence that Mr John took no action. It has always been accepted that more should have been done. This was reflected in his admission his response to the unexplained injuries being inadequate. The NMC's evidence is that Mr John was conducting an investigation into at least one of the resident's injuries [Main bundle, p46]. The panel is also aware that body maps had been taken and collated and were awaiting review.*

12. *There is no evidence that Mr John did not ensure staff followed the Home's policies in relation to Residents' falls in that Mr John did not action and/or escalate*

unexplained injuries. The panel is invited to find no case to answer in relation to this charge.

<u>Conclusion</u>

13. *The NMC has not produced any, or any sufficient evidence such that a reasonable panel, properly advised, could find charge 11b proved. The panel is invited to find that Mr John has no case to answer in relation to that charges, in accordance with Rule 24(7).*

Ms Cockburn referred to the CMF and submitted that you had originally admitted to all the charges related to Charge 11. She submitted that you would not have admitted to the Charges 11 (a) and (c) if there were no Home's policies. She added that the Maun View (the Home) is required to adhere to usual safe practise regarding any Residents' falls incidents. She further submitted that there was sufficient evidence in the bundle to suggest that you did not follow the Home's policy in relation to Residents' falls.

Ms Cockburn referred to the witness statement of Witness 2 dated 17 November 2020 which stated that:

'…The main concern we had was in relation to how the Home dealt with falls management and the risk assessments in relation to this. The Home had a falls prevention policy but this had not been consistently adhered to. One example from this first inspection was there was a resident who had been admitted to the Home in April 2019 and had an initial falls assessment which identified they were a known falls risk. This resident's care records showed they had a fall in May 2019 where they sustained some minor injuries. Following this fall, a new risk assessment was not completed to advise staff of the action required to reduce further risks…'

Ms Cockburn referred to the Care Quality Commission report (CQC) dated 26 July 2019 which stated that:

'….During our inspection on 25 July 2019 we observed body maps for 22 different service user detailing unexplained injuries…... We spoke with the manager who told us they were aware of the injuries and stated, some people bruised easily. We asked if any investigations had taken place and they told us they there investigating one injury as they were concerned about staff practice. The manager told us none of the unexplained bruising had been referred to the local authority safeguarding adults team, including the incident where there were concerns about the member of staff. Due to the lack of investigation and referral to safeguarding, there has been no learning and consequently there are no measures in place to reduce the likelihood of service users sustaining further injuries. Consequently, we remain concerned that people are at risk of abuse and improper treatment…'

Ms Cockburn submitted that that there was sufficient evidence to suggest that you had seen the injuries but there was no evidence to suggest that you had taken adequate action regarding the unexplained injuries.

In these circumstances, Ms Cockburn submitted that there is a case to answer in respect of the charge 11 (b).

The panel took account of the submissions made and heard and accepted the advice of the legal assessor. Ms Bayley and Ms Cockburn agreed with the legal assessor's advice that, should the panel decide you did have a case to answer, it should simply so state. Only if it determined that you did not have a case to answer should the panel state its reasons.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

Having carefully considered the submissions, the panel determined that there was a case for you to answer in that you did not adequately action unexplained injuries and it proposed to amend the Charge 11 (b) accordingly. As already stated, neither Ms Bayley on your behalf nor Ms Cockburn on behalf of the NMC opposed this proposal.

Decision and reasons on facts

Ms Bayley informed the panel that you admitted to Charges 2, 5, 6, 9(b), 9(e), 10 and 11.

The panel therefore found Charges 2, 5, 6, 9(b), 9(e), 10 and 11 proved, by way of your admissions.

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 Bayley on your behalf and the submissions made by Ms Cockburn on behalf of the NMC.

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

Background

On 17 December 2019, the NMC received a referral about your fitness to practise from the Human Resources Manager of Runwood Homes. The charges arose from a period whilst you were employed as a Home Manager at Maun View (‘the Home’) from 8 April to 29 July 2019. Allegedly, during your period of management at the Home, the CQC rating of the Home was downgraded from “requires improvement” to “inadequate”. The CQC report of the Home described the services provided by the Home as “not safe” and “not well led”.

Your name was first entered onto the NMC Register in April 2011. You qualified as a nurse in 2006. You began working at the Home on 8 April 2019. Prior to that, you had been working as a Home Manager from May 2015 to January 2018 at Knowle House, and from March 2018 to October 2018 at The Grange.

Shortly after you began working at the Home, a CQC Inspection took place on the 22 May 2019. The outcome of that inspection was a “requires improvement” rating. Allegedly, the concerns were brought to your attention, as the manager of the Home, by the CQC during that inspection. The issues which required improvement related to medicines management, how nutritional and hydration needs were met, the effectiveness of systems and risk assessments processes and how records were maintained. There were also issues with staffing levels which prompted the inspection.

A further inspection took place between 11 and 29 July 2019. You resigned from your position on the 28 July 2019. Following this inspection, the Home received an inadequate rating, and the Home provider was served with a notice of decision to impose conditions on its registration on 30 July 2019 as a result of the concerns identified. The CQC served this enforcement notice on the basis of the significant risk of harm identified during the inspection.

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

- Witness 1 (W1): Inspection Manager, Care Quality Commission (CQC).

- Witness 2 (W2): Inspector, Care Quality Commission (CQC).

The panel also heard evidence from you under oath.

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

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

Charge 1

'That you, a Registered Nurse, whilst employed as the Home Manager at Maun View Care Home ("the Home) between 8 April 2019 and 29 July 2019 did not ensure an adequate standard of care was provided to residents at the Home, as identified by the CQC following unannounced inspections in May and July 2019, in that you:

1) *Did not ensure that you/staff completed care plans to reflect Residents' needs.'*

This charge is found proved.

In reaching this decision, the panel had before it the CQC report dated 22 May 2019 in which it explains:

> *"Care plans provided staff with information about people's preferences, routines and what was important to them but varied in detail and at times was misleading."*

The panel also had before it the CQC report dated July 2019, at which time you had been employed as the manager of the Home for three months. Within this report it was detailed that care plans conflicted with risk assessments and that relatives were not always consulted about the plans put in place for the patients.

It is your case that you were not intimately aware of patients needs and therefore decided to delegate the responsibility to other staff members. The panel heard evidence that the care plans were completed electronically on hand-held devices. In your reflection you

explained that care plans were often completed in a hurry and that their contents did not always reflect the needs of the residents and that the handheld devices were often faulty. You told the panel that you did not want to tell senior managers this as it would look like you were 'going backwards instead of forwards'.

The panel had before it your job description which states:

> *"To ensure that care plans are completed, and are in place and cover all aspects of care that is required by the residents."*

The panel also bore in mind that you have admitted charge two, namely:

> 2) *Did not ensure that you/staff completed risk assessments*
> a) *To reflect Residents' needs; and/or*
> b) *That adequately mitigated risk.*

It determined that charge two was linked with charge one. Whilst the panel accept that during your interview for the job, issues within the Home may not have been disclosed to you, it determined that if the hand-held devices were faulty, it would have been reasonable to supplement the notes made on them with paper-based care plans on a transitional basis. The panel was of the view that completing care plans accurately was a fundamental responsibility given your role as a manager at the Home. In light of the job description before it and your admission to charge two, the panel was satisfied on the balance of probabilities that you did not ensure that you and/or staff completed care plans to reflect residents needs and therefore finds this charge proved.

Charge 3

> 3) *'Did not ensure that staffing levels were appropriate for the number of residents in the Home.'*

This charge is found NOT proved.

In reaching this decision, the panel had before it the CQC report dated July 2019 in which it states:

“Staffing and recruitment

- *Staffing levels were insufficient to meet people's needs and keep them safe. One nurse was dismissed for poor practise at the time of our inspection. This meant that the only qualified nurse directly employed by the service was the clinical lead.*
- *Agency nurses were bought in to cover the nursing unit. The agency nurses were not familiar with the home and concentrated on giving people their medicines and not the wider role required in nursing care. At our visit on 25 July 2019 we found that none of the staff working on the nursing unit knew the needs of the people placing them at risk of harm*
- *We saw examples where people had to wait a considerable length of time to have their needs met. One person told us, "It can be up to half an hour, it's the same at night time." A relative told us "I asked at a relatives' meeting if staffing had reduced as people were beginning to look scruffy. I was told that staffing had increased."*
- *One staff member told us, "I don't think there is enough staffing to cover holidays and sickness." Another staff member told us that they had previous experience in care. They told us that there had been no induction and when they had worked on the nursing unit a person asked for a drink. The staff said "I daren't give [named] anything in case she needed her drink thickening, it turned out that she did." This poses a risk to people who have swallowing problems if they were given un-thickened fluids by untrained staff.*
- *Robust recruitment processes were followed to ensure that people were protected from unsuitable staff. This included checks on staff employment history, DBS and identity.”*

In her oral evidence, W1 stated that Runwood had been giving you support in relation to staffing levels but that you had not indicated to her that you were struggling or that you had not been supported.

It is your case that you did raise issues with senior management including the CEO of Runwood, explaining that the Home did not have enough laptops, that members of staff were incompetent with technology, lacked training and that there was a number of staff on long term sick leave.

However, in cross-examination you contended that as of July, staff levels were appropriate.

The panel heard evidence that whilst you were on paternity leave, the Home employed a peripatetic manager (a turnaround manager). You denied that her employment suggested a criticism of your work as the Home manager.

The panel had before it your job description which states:

> *"To undertake or oversee effective recruitment to ensure that sufficient numbers of staff are of the right calibre to meet all aspects of residents' needs as specified by the registration department."*

It also states:

> *"To ensure revenue and staff costs are maintained as set out by Senior Management."*

The panel noted that you were employed at the Home for only 12 weeks. It accepted the evidence that you were not given a formal induction when you commenced employment and that the issues within the Home slowly become apparent to you, including a system where staff decided where they were going to work and refused to be relocated. The panel

was satisfied that you appropriately raised concerns regarding staffing levels, in that you contacted Runwood. The panel accepted the evidence that you were not allowed to replace staff members when they were on long term sick leave and that you did not have authority over the budget of the Home, which would have allowed you to employ additional staff. The panel was satisfied that based on the job description before it, the obligation to ensure staffing levels were appropriate was not upon you and that you made sufficient efforts to rectify the issues. The panel therefore determined that the NMC had not proved this charge on the balance of probabilities.

Charge 4

4) *'Did not ensure staff were deployed based on adequate/required skill sets.'*

This charge is found NOT proved.

In reaching this decision the panel considered the witness statement of W2, in which she states:

> *"I saw staff walk past people's open or closed doors when they were calling out for assistance without always stopping to assist. I also saw people calling for assistance when staff were not around, and I intervened on several occasions and requested staff support. I saw at lunchtime, how a resident was trying to eat with the handle of a knife and struggled for ten minutes before a staff member assisted the person to eat. This showed there was a lack of staff organisation and delegation."*

In her oral evidence W2 told the panel that she often saw staff watching residents struggling and seemed unaware that they needed help. It was her opinion that this showed a lack of staff organisation and delegation.

The panel also considered the witness statement of W1 in which she states:

"When we spoke to Binoy at the end of the inspection he did not appear to be aware that the staff deployed in the nursing unit did not know people's needs. We were forced to advise him that we would not leave the premises until suitably experienced staff were deployed on the unit. He advised he did not know people well enough to assist himself but uggested that the care team leader could be redeployed…" [sic]

The panel had before it your reflective piece in which you explain:

"We started doing competency for every medication administering staff and two or three weeks before I left, all competencies were done. Another note about supervisions and appraisals is that there was a chart on the wall in manager's office that showed all staff had supervisions in a timely manner, throughout a year or so. When spoke to the staff, to my surprise, most of them replied that they had not attended any supervision sessions for years which meant the records were all fake…

… As per my knowledge and experience, I made sure that the staff portfolios were sent to the home, prior to the shift and induction was made mandatory. As per the situation, there were 3 care staff each in every residential unit along with a clinical lead and there were 4 care staff and an RGN in the nursing unit. On top of this, the clinical lead stayed in the nursing unit and the deputy was asked to stay in the residential areas. The number of staffing was subject to change, based on the number and dependency of the residents. However, when the number of nursing clients reduced to 9, one day there were only 3 care staff and a nurse on duty…"

In your evidence in chief, you told the panel that you were misled as to the staff members' competency and that staff often refused to work within the nursing unit. You explained that on one occasion a staff member began to cry after she was told to relocate to the nursing unit. When questioned regarding the resident who struggled to feed himself for ten

minutes, you explained that staff at the Home are not there to take away a patient's independence. However, you accepted that ten minutes was an inappropriate length of time to leave a resident unassisted.

You confirmed that when you started working as the Home manager you delegated staff deployment to your deputy, who you explained was more familiar with the residents' needs.

The panel had before it a copy of your job description, which states:

> *"To ensure good quality working relationships are built and maintained between staff and the residents they are caring for."*

It also states:

> *"To undertake or oversee effective recruitment to ensure that sufficient numbers of staff are of the right calibre to meet all aspects of residents' needs as specified by the registration department."*

Whilst the panel did not accept that it was appropriate for you to fully delegate all your responsibilities to your deputy, it did note the evidence before it suggested a challenging staff environment including lack of training and competency. The panel was of the view that effective deployment of staff is determined by having appropriate staffing levels. The panel has already determined in charge three that it was not solely your responsibility to ensure that staffing levels were appropriate for the number of residents in the Home. You could only deploy the staff members available to you, including agency staff. In those circumstances the panel could not be satisfied on the balance of probabilities that it was your responsibility to ensure staff were deployed on adequate/required skill sets and therefore finds this charge not proved.

Charge 7

7) *‘Did not ensure there was adequate and/or safe handover systems in place.’*

This charge is found proved.

In reaching this decision the panel considered the oral evidence of W1. She explained to the panel that the electronic care plans are lengthy and that it is often difficult for agency staff to read and attain all the relevant information. W1 accepted that she did not expect managers to be present at every handover.

W2 told the panel that the staff ‘zipped through’ the handovers and information was not kept up to date. She stated that the quality of the information contained within the handover was very poor and described it as ‘very little and basic information’. When questioned, W2 accepted that you were not completely unresponsive to feedback but rather that the feedback provided was not implemented.

It is your evidence that the CQC approached you and asked you to create a paper-based version of the care plans. The plans were inspected by the CCG and they asked that you implement a seven day handover booklet, which you did. This requirement is evidenced within the Home Development Plan of 2019/20.

In your evidence in chief, you accepted that you did not attend handovers as the handovers occurred before you started your shift at 09:00. However, you informed the panel that you would completely a weekly audit of the handovers. You accepted that you should have attended more handovers in person and in your reflective piece you state:

> *“I should admit that I failed to check if they used this system appropriately so that handovers could be more meaningful and informative.”*

The panel had sight of the CQC letter of ‘Possible Urgent Enforcement Action’ dated 26 July 2019, which states:

"The agency nurse showed us them handover sheet, this contained very little information. It contained very basic information for seven of the 12 service users on the unit and very little information about clinical need. A new handover form had recently been introduced, however, this had not been completed on 25 July 2019. Furthermore, the information on the handover template was incomplete, for instances it did not state that MC had epilepsy – a significant clinical risk. Consequently, the agency nurse did not have adequate knowledge of the clinical needs of service users or some safety aspects of the home. For example, they were not sure if SC had a pressure ulcer and they were unaware of SC's moisture lesion. The did not know MC did not have epilepsy rescue medicines and they were also unaware that MC was not for hospital admission."

The panel also considered your job description. Whilst there is no specific reference to handovers, there is an obligation of you to ensure the health and safety of residents, specifically:

"To plan and facilitate regular and effective staff meetings to ensure that all staff are kept up to date with necessary information including, for example, current issues, initiatives for improvement, changes to operating procedures and reminders about company rules…

…Evaluate the risks of, and identify measures to protect Residents from hazards to their health, safety and welfare ensuring these preventative measures are communicated to staff."

The panel accepts that you implemented the seven-day handover booklet. However, it was of the view that auditing the handovers would not have been sufficient to ensure they were adequate and safe. The panel determined that it would have been appropriate for you to attend handovers in person occasionally during your 12-week employment at the Home to see how they were being carried out. The panel noted that you accept this

assertion. In light of your partial admission and all the evidence before it, the panel was satisfied on the balance of probabilities that you did not ensure there was adequate and/or safe handover systems in place.

Charge 8

8) *'Did not ensure Residents' nutritional and hydration needs were consistently and sufficiently:*
    a) *Assessed; and/or*
    b) *Monitored; and/or*
    c) *Reviewed.'*

This charge is found proved in relation to 8(b).

In reaching this decision, the panel had before it W1's witness statement, in which she states:

> *"We identified a number of residents who were at risk of dehydration due to inconsistent fluid management. Given the hot weather cited above, it is a reasonable expectation that temporary measures would be put in place to ensure service users had enough to drink in the hot weather. However, during our inspection visit on 25 July 2019 we found this was not the case. Fluid charts were in place for some service users, and these evidenced good fluid intakes.*
>
> *However, the approach to monitoring fluid intake was not consistent across all service users. For example, there was one resident we saw who had advanced dementia so consequently was unable to take care of her own hydration needs. Her care plan stated that fluids should be monitored but there was no fluid records for this resident that week at all. We looked at another resident's notes which described how this resident had been routinely declining drinks all week (since 22 July 2019) and some days was only recorded as drinking 30ml. Despite*

this nobody had decided to impellent a fluid chart or plan for this."

The panel noted that the concerns stated within W1's statement are echoed within the CQC letter of 'Possible Urgent Enforcement Action' dated 26 July 2019, a day after W1's inspection, which states:

"Service Users are at risk of dehydration. Given the hot weather cited above, it is a reasonable expectation that temporary measures would be put in place to ensure service users had enough to drink in the hot weather. However, during our inspection visit on 25 July 2019 we found this was not the case. Fluid charts were in place for some service users, and these evidenced good fluid intakes. However, the approach to monitoring fluid intake was arbitrary and not underpinned by good clinical decision making. Resident 2 has advanced dementia so consequently is unable to take care of her own hydration needs, Resident 2 was also observed to walk around the home almost constantly during our inspection so is likely to required enhanced fluid levels. care plan states that fluids should be monitored.

Despite this, fluids for Resident 2 are not being monitored. We observed there were no fluid records for Resident 2 at all week commencing 22 July 2019. This means there is no way of staff monitoring fluid and identifying potential dehydration. This places Resident 2 at risk of dehydration. Fluids are also not monitored for Resident 2. Daily recorded show that in week commencing 22 July 2019 they were routinely declining drinks or drinking a very small amount such as 30ml. This pattern had not been identified by staff and no fluid chart had been implemented. Records show that on 24 July 2019 Resident 2 sustained a fall and was admitted to hospital. Due to the lack of information about Resident 2 fluid levels it is possible that dehydration may have been a contributing factor leading to the fall."

It is your case that many residents required specific dietary requirements and in light of this, you carried out assessments and folders were made for the kitchen detailing those requirements. You told the panel that you had spoken with the chef of the Home who

confirmed that the menu had not been ‘changed in years’. In your reflective statement you explained the following in relation to the 2019 heatwave:

> *“Hydration trolleys were set which moved from room to room, unit to units, throughout the day. These trolleys had cool juices, water and ice lollies that were offered to the residents as well as the staff. Some residents still wanted to go and sit out in the garden. For such people, another cool bar was set up. They had sun screen lotions availed and they sat under parasols.”*

You told the panel that monitoring was completed by the deputy manager and clinical lead and that the matters were also discussed at ‘flash meetings’.

The panel noted the criticism of W2 by Ms Bayley in relation to this charge, specifically that her witness statement appears to refer to matters which were contained within the CQC report of May 2019, an inspection which she did not take part in.

However, the panel is of the understanding that you do not contest the facts that concerns regarding hydration and nutrition had been raised in May 2019. Against that background, the panel gave weight to the evidence of W1, who carried out the inspection in July 2019 and whose findings are supported by the CQC letter of ‘Possible Urgent Enforcement Action’ dated 26 July 2019. The panel accepted the evidence of W1. It concluded that whilst there was a system in place at the Home, it was not applied consistently and therefore the panel finds this charge proved in relation to 8 b).

Charge 9(a)

9) *‘Did not ensure medications were safely and/or effectively managed in that:*
   a) *Medication was not consistently;*
      i) *ordered;*
      ii) *stored;*
      iii) *administered;*

iv) disposed of.'

This charge is found proved in relation to 9(a)(ii) and (iv) only.

In reaching this decision, the panel had regard to the witness statement of W2, in which she explains:

> *"There were a number of concerns in relation to medication management witnessed during the inspections. Prescribed medicines were not always ordered, stored, administered and disposed of consistently.... Another resident had ran out of thickening agent prescribed for their drinks and a new prescription hadn't been ordered. I spoke to one of the nurses who advised this was ordered but they wasn't able to evidence this."*

The panel also considered your reflective piece in which you detail the issues surrounding medication management within the Home. You described how some medication had not been disposed of for a year. You explained that a non-compartmentalised trolley was in use within the nursing unit, that medications were put in the trolley without any order and that staff had to spend a long time searching for medications. Further, you stated that residents' medication folders did not contain vital information and/or photos of residents. You also described how a lot of staff within the Home had their 'own way of doing things' and that their procedures were not always safe. This is something you highlighted and questioned on a number of occasions. Further, it is your evidence that you raised these issues with Runwood, including a request for a new trolley but that these requests were not granted.

The panel noted that at the time the allegations arose, you had inherited a chaotic medication system whereby the nursing unit was been supplied medication by the local pharmacy and the residential unit was been supplied medication by Boots. It considered the evidence that because no contract had been set up with the local pharmacy, the

nursing unit was required to use the residential trolley, which was not a satisfactory arrangement.

The panel considered the fact that you have admitted limbs b) and e) of this charge. It was of the view that by admitting those limbs, you are accepting that it was your responsibility as the Home manager to ensure medications were safely and/or effectively managed. Further, it is your own evidence that medication was not stored or disposed of properly. The panel therefore finds limbs ii) and iv) proved.

In relation to limbs i) and iii) the panel considered the fact that it did not have before it any evidence, for instance residents' MAR charts demonstrating the administration of medication. In light of this, the panel concluded that the NMC had not discharged its burden on the balance of probabilities and therefore finds limbs a) i) and ii) not proved.

Charge 9(c)

c) *'Resident 1's prescribed medication was stored without a pharmacy label and instead had a handwritten label with no administration details.'*

This charge is found NOT proved.

In reaching this decision, the panel referred to the witness statement of W2 in which she describes:

> *"One resident had a prescribed medication without a pharmacy label, it had a hand written label with no administration details."*

It is W2's evidence that she had seen the label herself. You told the panel that you did not recall this incident.

The panel did not have any other evidence before it to support this charge. The panel again noted the criticism of W2 by Ms Bayley in relation to this charge, specifically that W2's witness statement appears to refer to matters which were contained within the CQC report of May 2019, an inspection which she did not take part in. This is contradictory to W2's claim that she saw the label herself.

Given the insufficient evidence before it and the apparent contradictions of W2's evidence, the panel concluded that the NMC had not discharged its burden on the balance of probabilities and therefore finds this charge not proved.

Charge 9(d)

d) *'Instructions on the method of administration of medication were not always documented.'*

This charge is found NOT proved.

When making its decision the panel referred to the witness statement of W1, in which she states:

> *"I reviewed some aspects of medicines management. There was one resident who had insulin dependent diabetes. This resident had an insulin pen which states 'to be given as directed' but nobody seemed to know how much insulin was given and when. The MAR Chart didn't have the dose of time but had been signed. I actually had to intervene in regards to this and say that no further doses were to be given until this resident had been assessed by a GP and clear instructions given."*

The panel did not have any other evidence before it in relation to this charge. Further, it noted that the mischief within W1's statement relates to the recording of administration

rather than the method of administration. In light of this, and given the wording of the charge, the panel finds this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether 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

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

Ms Cockburn invited the panel to take the view that the facts found proved amount to misconduct. She referred the panel to the terms of the NMC Code [*The Code: Professional standards of practice and behaviour for nurses and midwives (2015)*] to

assist it in making its decision. Ms Cockburn submitted that your actions breached a number of standards of the Code and highlighted specific paragraphs for the panel's consideration. She submitted that over the course of your employment at Maun View, you had demonstrated an unacceptably low standard of professional performance which risked patient safety. She further submitted that your failings had caused vulnerable residents harm and exposed them to risk of harm.

Ms Cockburn submitted that as you had considerable experience of working in care homes and had previously held a managerial role in another care home, you would have been aware before you started at Maun View that it was your responsibility as manager to ensure that residents were afforded basic care. She further submitted that your failings were not isolated but were numerous and wide-ranging, and accordingly, they amounted to misconduct.

In her written and oral submissions on your behalf, Ms Bayley reminded the panel that you had admitted the 'vast majority' of the charges or had made concessions in the course of your evidence. While it remains a matter for the panel's determination, it did not understand Ms Bayley to be contending that the matters found proved did not amount to misconduct. Indeed, she appeared to concede this, at least implicitly, in paragraphs 27 and 28 of her written submissions.

Submissions on impairment

Ms Cockburn next addressed the matter of impairment and the need for the panel to have regard to protecting the public and the wider public interest. This includes declaring and maintaining proper standards of conduct and performance as well as maintaining public confidence in the profession and in the NMC as its regulator.

Ms Cockburn referred the panel to *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). She submitted that patients had suffered harm and distress as a result of your conduct, and their health

and wellbeing had been at risk. Ms Cockburn submitted that your actions had breached fundamental tenets of the profession and had brought it into disrepute.

Ms Cockburn submitted that your fitness to practise is currently impaired. She submitted that your misconduct has not been remedied and is likely to be repeated. Ms Cockburn submitted that you have not fully accepted responsibility for your actions, instead criticising the effect the CQC inspections had on your ability to manage the home and deflecting responsibility onto others. She submitted that you had reflected on the effect your time as a manager of Maun View had on you and your family, rather than the impact it had on residents, colleagues, or the reputation of the profession.

Ms Cockburn further submitted that the references submitted do not contain sufficient details about your management skills or your ability to deal with patient safety concerns. Furthermore, she submitted that the training records you provided raised concerns about the depth of content of the courses you attended. Ms Cockburn also submitted that your description of the current restrictions on your practice was inaccurate.

Ms Bayley disputed that you had not taken responsibility for your actions. She invited the panel to take into account the context you were working in and submitted that whilst you were unable to deliver change to Maun View as quickly as was required, your intention was to make improvements to the Home for the good of the residents. Ms Bayley submitted that you had never intended to cause harm or put residents at risk of harm.

Ms Bayley submitted that you had undertaken targeted training and reflection, and had considered your failures objectively and in the light of their impact on patients and the profession. She submitted that you have shown a deep understanding of what you have done wrong, why it was wrong, and have taken steps to ensure that your misconduct is not repeated. Ms Bayley submitted that you have shared your experience and learning with others; your independent learning and library research and conversations with other practitioners has helped you to develop significant insight into the consequences of your

actions. This was also demonstrated by the reflective pieces you had put before the panel, especially the most recent.

Ms Bayley submitted that in the light of your sincere remorse, remediation, insight, reflection, training and previous and subsequent good practice, the risk of repetition of the misconduct is low. Consequently, a finding of impairment on the grounds of public protection is not necessary.

Ms Bayley submitted that the public interest has been served by the thorough NMC investigation and forensic scrutiny applied to your practice as well as the findings of fact in this case, and accordingly, a finding of impairment in the public interest is not required.

The panel accepted the advice of the legal assessor.

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. It considered that your actions breached the following standards of the Code:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively.

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

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.

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

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

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues.

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.

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.

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.5 complete the necessary training before carrying out a new role.

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

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

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices.

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.

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.4 take all steps to keep medicines stored securely.

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code.

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

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel considered the serious implications of your actions on vulnerable residents, the actual harm they experienced and the potential for further harm. It considered that your failures were not isolated but were wide-ranging and had occurred throughout the 15-week period of your employment at Maun View. The panel is of the view that individually and collectively, your actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to serious professional 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 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 paragraph 74, she said:

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

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *[…].’*

The panel finds that residents were put at risk as a result of your misconduct. Your misconduct has breached the fundamental tenets of the nursing profession and brought its reputation into disrepute.

With regard to *Cohen v General Medical Council* [2008] EWHC 581 (Admin), the panel considered whether your fitness to practise is currently impaired.

The panel is satisfied that the misconduct in this case may be capable of being remedied. It has carefully considered your insight into your misconduct and the steps you may have taken to strengthen your practice.

The panel found your reflections to be credible and demonstrative of you accepting responsibility for your actions. You have an understanding of the impact of your failures on patients and have taken ownership of the concerns in the charges found proved or to which you admitted. The panel noted evidence of supervision and of you having professional conversations with colleagues in relation to the areas of concern. It also noted that you have undertaken independent research to supplement your knowledge. The panel considered that your insight has developed.

The panel noted the considerable number of training certificates you have provided, which evidence continuous learning in specific areas of concern. However, the panel does not have the benefit of your written reflection on the learning you have gained from this training and how you have applied it to your practice. The panel noted that the references provided are recent and date from July 2023, reflecting the short amount of time you have been working with your current employer. The panel therefore does not have a reference evidencing a longer track record of your ability to safely practise as a registered nurse. The misconduct in this case is serious, and whilst you have taken steps to improve your practice and shown insight into your failings, the panel cannot conclude at this stage that there is a low to no risk of repetition. In the panel's opinion, there remains a real risk of repetition of your misconduct. Accordingly, the panel finds that your fitness to practise is currently impaired on public protection grounds.

The panel has borne 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 is satisfied that the public interest has been served by the robustness of the NMC investigation and fitness to practise proceedings over the past four years, as well as the findings of fact in this case. It considered that a fully-informed member of the public with an understanding of the wider contextual issues would not expect a finding of

impairment in order to maintain public confidence in the profession, and accordingly determined that a finding of impairment is not required in the public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of nine months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and to the NMC's published guidance on sanction ('the SG').

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Cockburn invited the panel to impose a suspension order of four months. However, she submitted that if the panel were minded to impose a conditions of practice order, the existing interim conditions of practice that are currently imposed on your registration are appropriate and proportionate in order to protect the public.

Ms Cockburn highlighted the aggravating features of this case as being the wide-ranging nature of the concerns which were repeated throughout the course of your employment at Maun View. She also highlighted the serious implications your actions had on vulnerable residents who experienced actual harm and were placed at risk of further harm. In mitigation, Ms Cockburn submitted that you were newly appointed and not supported by

your employer. She submitted that you had engaged with these proceedings and had developed some insight.

Ms Bayley submitted that neither temporary nor permanent removal from the register was appropriate. She submitted that a conditions of practice order of nine months is the appropriate and proportionate order. Ms Bayley invited the panel to consider your attitude towards the misconduct and your acceptance of responsibility for the harm it caused to residents, their families, your colleagues and the wider nursing profession. She submitted that your remorse was genuine and heartfelt, and reminded the panel of the extensive reflections, relevant training, independent learning and discussions with colleagues you had undertaken in order to improve your practice. Ms Bayley submitted that, while the fact that patients experienced harm is an aggravating feature, this is tempered by the fact that you did not deliberately intend to harm any of the patients.

Ms Bayley invited the panel to impose the existing interim conditions of practice as the substantive conditions of practice, subject to some amendments. She submitted that you were content to continue with not undertaking a care home management role. However, she submitted that the conditions that limit you to working for a sole employer, prevent you from supervising staff, and require you to be indirectly supervised are disproportionately restrictive and are causing you financial hardship.

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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your misconduct put vulnerable patients at risk of suffering harm.
- There was a pattern to your misconduct which took place over a period of time.

The panel also took into account the following mitigating features:

- You were newly appointed to your role as manager with little to no support from your employer. You had not received an induction. The panel heard evidence that Maun View was already an organisation with serious failures before your arrival.
- You have apologised for your actions and have shown developing insight.
- You have taken steps to strengthen your practice, including reflecting, undertaking multiple training courses, and engaging in independent learning and research.

Although the panel did not consider it to be a mitigating feature, it acknowledged your engagement with the NMC throughout the course of its investigation and these proceedings.

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

It then considered the imposition of a caution order but, again, determined that due to the seriousness of your misconduct and the public protection concerns 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 determined 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 is the appropriate and proportionate response. The panel is mindful that any conditions

imposed must be proportionate, measurable, and workable. The panel considered that the following factors listed in the SG which may indicate that a conditions of practice order is appropriate and proportionate are engaged:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is satisfied that it is possible to formulate practical conditions of practice which would address the failings highlighted in this case. It has had regard to the context of this case and is mindful that with the appropriate safeguards, it is in the public interest that you should be allowed to continue to practise as a nurse.

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

The panel is of the view that either temporary or permanent removal from the register is disproportionate in the circumstances and is not required in this case. It is satisfied that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standard of practice required of a registered nurse.

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

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

1. You must not be employed as or act in a management position with overall management responsibility for any home, or for any care or nursing establishment.

2. You must work for a sole employer. This can be an agency, but any placements you undertake through an agency must be for a minimum of two months.

3. You must meet with your line manager, mentor or supervisor or their nominated deputy on a weekly basis to discuss your clinical caseload.

4. You must meet with your line manager, mentor or supervisor or their nominated deputy on a monthly basis to undertake clinical supervision.

5. You must provide a report from your line manager, mentor or supervisor or their nominated deputy to the NMC prior to any review hearing that outlines your performance in relation to your clinical practice.

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

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

8. You must immediately give a copy of these conditions to:

a. Any organisation or person you work for.
b. Any agency you apply to or are registered with for work.
c. Any employers you apply to for work (at the time of application).
d. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
e. Any current or prospective patients or clients you intend to see or care for when you are working independently.

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

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

The period of this order is for nine months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- An updated reflective piece which includes the actions you have taken for your further development.

- Certificates of relevant learning accompanied by a brief reflective summary on how your learning applies to your practice.
- Testimonials and references, including any testimonials that post-date this hearing which demonstrate a period of safe practice which precedes and continues throughout the period of this order.

This will be confirmed to you in writing.

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, and if you do appeal, until your appeal has been determined, 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 is in your own interests until the conditions of practice sanction takes effect.

The panel accepted the advice of the legal assessor.

Submissions on interim order

Ms Cockburn submitted that an interim conditions of practice order of 18 months is necessary on the same grounds for imposing the substantive order.

Ms Bayley did not oppose the application.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months.

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

That concludes this determination.