Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

Tuesday, 5 November – Friday, 22 November 2024

Monday, 31 March – Wednesday, 2 April 2025

Tuesday, 1 July 2025

Thursday, 24 – Friday, 25 July 2025

Virtual Hearing

Name of Registrant:	**Clare Christine Sullivan**
NMC PIN	08C0070E
Part(s) of the register:	Registered Nurse – Adult Nursing RNA – (27 September 2008)
Relevant Location:	Liverpool
Type of case:	Misconduct
Panel members:	Avril O'Meara (Chair, Lay member) Helen Chrystal (Registrant member) Kamaljit Sandhu (Lay member)
Legal Assessor:	Charles Conway (5 November – 22 November 2024) Paul Hester (31 March – 2 April 2025, 1 July 2025) Graeme Henderson (24 and 25 July 2025)
Hearings Coordinator:	Khatra Ibrahim (5 November – 22 November 2024, 31 March – 2 April 2025, 1 July 2025) Nicola Nicolaou (24 and 25 July 2025)
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Mrs Sullivan:	Present and represented by Elisabeth MacDermott (formerly Elisabeth Komives), instructed by the Royal College of Nursing (RCN)

NMC Offering no Evidence:	Charges 10, 13, and 22
Facts found proved by way of admission:	Charges 1a, 1b, 2, 3a, 3b(i), 3b(ii), 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7a, 7b, 8, 9, 11a(i), 11a(ii), 11b, 12, 14, 15, 16a, 16b, 17, 18a, 18b, 18c, 19, 20, 21a, 21b, 23, 24, 25, 26a, 26b, 27, 28, 29, 30a, 30b(i), 30b(ii), 31, 32a, 32b, 33, 34a, 34b, 35, 36, 37, 38, 39a, and 39b
Fitness to Practise:	Impaired
Sanction:	**Suspension order (3 months) without a review**
Interim Order:	**N/A**

Background

You were referred to the Nursing and Midwifery Council (NMC) on 23 May 2022 by Lotus Care ('Lotus'). You are a registered nurse and were employed by Lotus as the Registered Manager of Cressington Court Care Home ('the Home'), between November 2018 and April 2022. The Home was a residential care home that provided nursing and personal care for up to 56 residents. The Care Quality Commission (CQC) regulated the premises, and the nursing care provided at the Home.

In November 2019, the CQC rated the Home "*Requires Improvement*". On 24 March 2022, the CQC attended the Home to carry out an unannounced inspection. Further inspections took place on 31 March 2022, 11 April 2022, and 20 April 2022. Following these inspections, the CQC published an Inspection Report in August 2022 and rated the Home "*Inadequate*". The CQC found that the Home was not "*well led*" and the Registered Manager and Provider had failed in a number of their regulatory responsibilities. Concerns included:

- Failure to ensure that the emergency call bell system was not fully operational;
- Failure to ensure compliance with fire safety standards, in that:
- 16 Personal Emergency Evacuation Plans (PEEPS) did not contain correct information, or were not in place;
- A number of bedroom doors did not fully close; and
- All staff had not been trained in fire awareness and emergency evacuation processes.
- Failure to ensure safe and effective management of medicines, including:
- Failure to ensure safe practice around the use of enteral feeding tubes;
- Residents put at risk of choking and aspiration because SALT guidelines were not implemented or followed;
- Failure to ensure that residents received their medications as prescribed on multiple occasions.
- Failure to safely admit residents during the Covid-19 pandemic; and

- Failures in medication management and administration.
- Failure to ensure that residents at risk of falling were effectively risk assessed and the risk of harm mitigated.
- Failure to ensure that staff carried out safe moving and handling procedures.
- Failure to ensure that residents were effectively assessed in relation to damage to their skin, including allegations that wounds were not properly monitored.

Following the inspections, on 25 March 2022, the CQC issued a letter of intent of potential enforcement action, which detailed an action plan to address the concerns identified, this action plan was submitted on 28 March 2022. The CQC imposed a section 30 Notice on the Home on 12 April 2022 and on 27 July 2022, the CQC issued a Notice of Decision to cancel the Home's registration as a service provider for people requiring nursing or personal care. This ultimately resulted in the nursing unit in the Home closing down and the residents in that unit being rehomed. Following the CQC's inspections in April 2022, you resigned from your position as the Registered Manager of the Home.

Application to amend the charges

On 6 November 2024, the panel heard an application made by Mr Kennedy, on behalf of the NMC, to amend the wording of charge 39a.

The proposed amendment was to remove the word "*Adequately*" and replace it with "*Fully*". He further proposed to add "*in all mandatory areas*" to charge 39a. It was submitted by Mr Kennedy that the proposed amendment would provide clarity and more accurately reflect the evidence before the panel.

> "That you, a registered nurse whilst working as the Registered Manager of Cressington Court Care Home:
>
> 39. In or around March 2022, failed to ensure that staff were:

a) ~~Adequately~~ **Fully** trained in **all mandatory areas.**

Ms MacDermott, on your behalf, did not oppose the 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', as amended (the Rules).

Decisions and reasons on application to amend charges

The panel noted that the application was not opposed by Ms MacDermott. The panel accepted Mr Kennedy's submissions that the proposed amendments would provide more clarity and allow you to better understand the charge. The panel determined that the amendment, as applied for, was in the interest of justice and that there would be no prejudice to you and no injustice caused to either party by the proposed amendment being made.

The panel granted the application to amend charge 39a.

Second application to amend the charges

On 6 November 2024, the panel heard a further application from Mr Kennedy, to amend the wording of charges 7a, 30, and 37:

"That you, a registered nurse whilst working as the Registered Manager of Cressington Court Care Home:

'7.Between 12 April 2022 and 16 April 2022, failed to ensure that:

a) Resident C's fluids care plan was sufficient and/or accurately reflected [PRIVATE] **Resident C's** needs.

30. Following loss of weight ~~of~~ **by** Resident I between 11 March 2022 and 12 April 2022, failed to ensure that:

a) The correct records were completed for Resident I's referral to a dietician.
b) Resident I 's dietary care plan and/or risk assessment:
i) Had been updated in light of the weight loss.
ii) Was being followed.

37. Between 1 March 2022 and ~~12~~ **10** April 2022, failed to ensure that the emergency call bell system was maintained in good working order.'

Mr Kennedy submitted that the proposed amendments should be made for the following reasons:

In respect of charge 7a the letters [PRIVATE] should be replaced with Resident C to protect the anonymity of Resident C.

In respect of charge 30 the word "*of*" should be deleted to make grammatical sense of the charge.

In respect of charge 37, the date should be amended to 10 April 2022 to reflect the evidence before the panel which noted that by 11 April 2022, the emergency call bell was working.

Mr Kennedy submitted that the proposed amendments were in the nature of typographical errors and did not affect the nature of the charges.

Ms MacDermott did not oppose the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

Decisions and reasons to amend the charges

The panel noted that Ms MacDermott did not oppose the application.

The panel determined that for the reasons set out by Mr Kennedy, it was in the interests of justice to allow the amendments. The panel was satisfied that the amendments do not change the nature of the charges. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed.

The panel therefore granted the application.

Details of charge (as amended)

That you, a registered nurse whilst working as the Registered Manager of Cressington Court Care Home:

In respect of Resident A

1.Following a Speech and Language Therapy ('SALT') assessment on 25 February 2022, that advised Resident A be given level 2 thickened fluids, failed to ensure that:

a) The provision of foods and/or fluids to Resident A was in line with the advice in the SALT assessment.
b) Resident A's MAR chart was accurate regarding the level of thickener required.

2. Between 21 March 2022 and 11 April 2022 failed to ensure that Resident A's daily fluid target was reached on one or more occasions.

3. Following loss of weight by Resident A, between 1 September 2021 and 4 April 2022, failed to ensure that:

a) Resident A was referred to a dietician.
b) Resident A's dietary care plan and/or risk assessment:

i) Had been updated in light of the weight loss.
ii)Was being followed.

In respect of Resident B

4. In March 2022, failed to ensure that Resident B received:

a) The prescribed dosage of Fresubin (nutritional supplement) on three or more occasions.
b) The prescribed dosage of Levothyroxine (hypothyroidism treatment medication) on six or more occasions.
c) The prescribed dosage of Ensure (nutritional supplement) on one or more occasions.

In respect of Resident C

5.Following loss of weight by Resident C between 25 October 2021 and 27 March 2022, failed to ensure that:

a) Resident C's dietary care plan and/or risk assessment:
i) Was updated in light of the weight loss.
ii) Was being followed.
b) Resident C was referred to a dietician in a timely manner.

6.Following Resident C's Speech and Language Therapy ('SALT') review on 5 April 2022 that advised that Resident C be given level 2 thickened fluids and level 4 pureed foods, failed to ensure that:

a) Resident C's care plan had been updated regarding the advised thickener level and/or risk of aspiration.
b) The provision of foods and/or fluids to Resident C was in line with the advice in the SALT assessment.

7.Between 12 April 2022 and 16 April 2022, failed to ensure that:

a) Resident C's fluids care plan was sufficient and/or accurately reflected Resident C's needs.
b) Resident C's daily fluid target was reached on one or more occasions.

In respect of Resident D

8.Failed, by 11 April 2022 to ensure that there was care planning and/or a risk assessment in place regarding the management of Resident D's enteral feeding tube.

9.Following a Speech and Language Therapy ('SALT') assessment on 22 October 2021, that advised Resident D to be given level 2 thickened fluids and level 4 pureed meals, failed to ensure that the provision of foods and/or fluids to Resident D was in line with the advice in the SALT assessment

10.On 31 March 2022, failed to ensure that the handover record indicated that Resident D had in place a DNACPR order.

11.Following loss of weight by Resident G, between 21 March 2022 and 31 March 2022, failed to ensure that:

a) Resident G's dietary care plan and/or risk assessment:
i) Had been updated in light of the weight loss.
ii) Was being followed.
b) Food and/or fluid charts were kept for Resident G.

12.On 31 March 2022 failed to ensure that Resident D was repositioned in a timely manner to avoid risk of skin damage.

13.On 31 March 2022, following Resident D's readmission from hospital, whilst national guidance for the management of the spread of Covid-19 was in

operation, failed to ensure that Resident D was placed in isolation from other residents.

14.Between 21 March 2022 and 11 April 2022, failed to ensure that Resident D's diet and fluid charts were accurately and/or sufficiently completed.

In respect of Resident E

15.Failed by 12 April 2022 to ensure that a 'root cause analysis' document had been completed to investigate Resident E's pressure wound.

16.Following loss of weight by Resident E between 20 January 2022 and 9 February 2022, failed to ensure that:

a) Resident E's food and/or fluid intake was adequately recorded.
b) Resident E was referred to a dietician in a timely manner.

In respect of Resident F

17.Failed, by 28 March 2022 to ensure that there was a care plan and /or risk assessment in place for Resident F's pressure wound.

18.In regard to Resident G's penile catheter failed by 20 April 2022 to ensure that:

a) A care plan and/or risk assessment was in place.

b) The catheter had been changed within an appropriate time.

c) There was sufficient equipment available for re-catheterisation.

19.Between 31 March 2022 and 11 April 2022 failed to ensure that Resident F's fluid intake and output was monitored and/or recorded.

In respect of Resident G

20.Between 20 March 2022 and 31 March 2022 failed to ensure that adequate wound care was provided to Resident G.

21. Between 29 February 2022 and 30 March 2022, failed to ensure that:

a) Resident G's Bimatoprost (glaucoma treatment) had been administered and /or recorded on at least five occasions.
b) Resident G 's refusal of Bimatoprost (glaucoma treatment) was escalated to the GP or ophthalmologist.

22.On 31 March 2022, following Resident G 's readmission, whilst national guidance for the management of the spread of Covid 19 was in operation failed to ensure that Resident G was placed in isolation from other residents.

In respect of Resident H

23. On 30 March 2022, following Resident H's readmission, whilst national guidance for the management of the spread of Covid 19 was in operation, failed to ensure that Resident H was placed in isolation from other residents.

24.On 31 March 2022 failed to ensure that the handover record/document indicated that Resident H had in place a DNACPR order.

In respect of Resident I

25.Between 18 March 2022 and 11 April 2022, failed to obtain a nebuliser for Resident I.

26. Failed by 20 April 2022 to ensure that:

a) Prescribed intravenous paracetamol medication was administered to Resident I on one or more occasion.
b) Alternative pain relief was obtained for Resident I.

27. Between 18 March 2022 and 11 April 2022 failed to ensure that Resident I was administered Peptamen liquid on 3 or more occasions.

28. Between 18 March 2022 and 11 April 2022, failed to ensure that Resident I was administered the prescribed amount of sterile water on 5 or more occasions.

29. Following a Speech and Language Therapy ('SALT') assessment, which took place before 11 April 2022, that advised that Resident I be given level 2 thickened fluids, failed to ensure that the provision of fluids to Resident I was in line with the advice in the SALT assessment.

30. Following loss of weight by Resident I between 11 March 2022 and 10 April 2022, failed to ensure that:

a) The correct records were completed for Resident I's referral to a dietician.
b) Resident I 's dietary care plan and/or risk assessment:
i) Had been updated in light of the weight loss.
ii) Was being followed.

In respect of Resident J

31. Between November 2021 and March 2022, failed to ensure that staff were trained in and /or using safe moving and handling techniques.

In respect of Resident K

32.Following an unwitnessed fall by Resident K on 18 March 2022 failed to ensure that:

a) Guidance provided in Resident K's falls diary was being followed.
b) One or more of Resident K's further falls was adequately risk assessed.

In respect of Resident L

33. In March 2022, failed to ensure that Resident L's fluid intake had been consistently monitored.

34. In or around March 2022, failed to ensure that residents' Personal Emergency Evacuation Plans (PEEP) were:

a) Accurate.
b) Appropriately reviewed.

35. In or around March 2022, failed to ensure doors in residents' rooms were able to fully close to prevent the risk of the spread of fire and smoke.

36. In or around March 2022, failed to ensure that all staff had up to date fire safety training.

37. Between 1 March 2022 and 10 April 2022, failed to ensure that the emergency call bell system was maintained in good working order.

38. Between 15 August 2021 and 11 April 2022, failed to complete weekly audits of controlled drug stock.

39. In or around March 2022, failed to ensure that staff were:

a) Fully trained in all mandatory areas.
b) Appropriately supervised.

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

The charges were read into the record. You made admissions to all of the charges.

The panel found all of the charges proved by way of your admission.

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 ability to practise kindly, safely and professionally.

You gave evidence under affirmation.

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

During your oral evidence, Ms MacDermott made a request that this case be held partly in private on the basis that proper exploration of your case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the Rules.

Mr Kennedy did not oppose the application.

The legal assessor gave advice and 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 that as and when matters relating to [PRIVATE] are discussed, it is in the interests of justice to hear these in private to protect your privacy.

Panel concerns relating to the charges

During its deliberations on misconduct the panel had some concerns regarding certain charges. The panel reconvened the hearing on Monday 18 November 2024 and identified that the evidence provided to it, including the oral evidence from you, suggested that only one resident had been readmitted to the Home on 30-31

November 2021, and not three residents as set out in charges 13, 22, and 23. Similarly, it queried whether there was evidence for two residents in relation to charges 10 and 24 or only one resident. The panel also had concerns in relation to whether the correct resident had been identified in charges 11, 18, 19, and 32. The panel invited Mr Kennedy and Ms MacDermott to consider these matters and adjourned to allow them time to do so.

On 19 November 2024, Mr Kennedy informed the panel that having considered the unredacted evidence relating to these charges, he concluded that there was no evidence to support charges 10, 13, and 22 and that these charges were "*ill-informed*". He told the panel that there was evidence before it to support the charges that Resident H had been readmitted to the Home from hospital on 30 March 2021, and there had been failures in relation to their readmission and handover. He also told the panel that in relation to Resident D and Resident G, the evidence pointed to these residents being present in the Home and receiving care on 30-31 March 2021.

Mr Kennedy informed the panel that in relation to charges 11 and 18 there was no evidence in support of these charges. In his view, the wrong resident had been identified in the charges. Charge 11 should read Resident G, not Resident D and Charge 18 should read Resident G, not Resident F.

In relation to charges 19 and 32, Mr Kennedy said that he was satisfied that these charges referred to the correct residents. However, he noted that errors had been made in the redaction exercise in Witness 1's witness statement which referred to Resident G. Mr Kennedy stated that Witness 3's witness statement referred correctly to Resident F. In addition, Mr Kennedy said that evidence in support of charge 19 could be found in Resident F's records which were before the panel.

In relation to charge 32, Mr Kennedy said that there appeared to be an error in Witness 1's statement as opposed to a redaction error and pointed to Witness 3's statement as correctly referring to Resident K. However, there were no records provided to the panel in respect of Resident K, he could not provide any further details in relation to this charge.

Application to vacate your admissions to charges 10, 11, 13, 18 and 22

On 19 November 2024, Ms MacDermott made an application to vacate your admissions to charges 10, 11, 13, 18 and 22 on the grounds of fairness. She submitted that you had admitted to these charges on an erroneous basis and it has since become clear that there is no evidence to support these charges.

Mr Kennedy did not oppose the application. He submitted that it is for the panel to regulate its own proceedings under Rule 24 of the Rules, subject to the principles of fairness and natural justice. He submitted that charges 10, 13 and 22 were "*ill-informed"* and there was no evidence to support these charges. Mr Kennedy agreed that you had made admissions on an erroneous basis, and that it would not be fair for the NMC to proceed with the aforementioned charges. He also submitted that in regard to charges 11 and 18, he does not object to your admissions being vacated, as these charges refer to the wrong residents.

The panel accepted the advice of the legal assessor.

The panel took into account the submissions of Mr Kennedy and Ms MacDermott, and determined that your admissions of charges 10, 11, 13, 18 and 22 should be vacated. It determined that vacating your admissions to these charges would be fair to you and in the interests of justice. The panel noted that you made the admissions on the basis that as the Registered Manager of the Home, you were responsible for managing the Home and overseeing the care and safety of the residents. You also told the panel in oral evidence that you were only aware of one resident being readmitted to the Home on 30-31 March 2021. It is clear to the panel from your evidence that although you did not know about all the incidents set out in the charges, your full admissions to the charges were on the basis that as the Registered Manager you were responsible for managing and overseeing the Home.

The panel noted that Mr Kennedy did not oppose the application. The panel accepts there is no evidence in relation to charges 10, 13 and 22 and that the evidence before it points to the wrong residents being identified in charges 11 and 18. The

panel therefore determined that it is fair and in the interests of justice to allow you to withdraw your admissions to these charges.

The panel granted the application to vacate your admissions to the charges.

Application to offer no evidence

The panel considered an application from Mr Kennedy to offer no evidence in respect of charges 10, 13 and 22.

In relation to this application, Mr Kennedy submitted that following the panel's decision to vacate your admission to these charges, the position of the NMC has significantly changed. He submitted that he must now consider what evidence there is to support these charges, and in his view, there is none. He referred the panel to the NMC Guidance on "Offering No Evidence" DMA-3, which advises that where there is no longer any realistic prospect of the factual allegation being proved the NMC will apply to offer no evidence.

Mr Kennedy submitted that in relation to these charges, the Case Examiner's decision was made on an incorrect basis. He submitted that there has been a change in circumstance because there is no information before the panel to support these charges. In the circumstances, he submitted that these charges should not be allowed to remain before the panel.

Ms MacDermott did not object to the application.

The panel accepted the advice of the legal assessor.

Decisions and reasons on application to offer no evidence

The panel took account of the submissions. The panel bore in mind the NMC Guidance on "Offering no Evidence" DMA-3.

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 any evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel determined that taking account of all the evidence before it, there was no realistic prospect that it would find charges 10, 13, and 22 proved. The panel determined that there were no further steps or investigations the NMC could reasonably carry out to provide evidence of these charges. It noted that Mr Kennedy had reviewed the records for Residents D and G, and they were residents at the Home and were receiving care on 30-31 March 2022.

The panel was satisfied that there is no evidence to support charges 10, 13, and 22 and therefore it accepted the NMC's application to offer no evidence.

Third application to amend charges

On 19 November 2024, Mr Kennedy made an application to amend charges 11 and 18 as follows:

> 11.Following loss of weight by Resident ~~D~~ **G**, between 21 March 2022 and 31 March 2022, failed to ensure that:
>
> a) Resident ~~D's~~ **G's** dietary care plan and/or risk assessment:
> i) Had been updated in light of the weight loss.
> ii) Was being followed.
> b) Food and/or fluid charts were kept for Resident ~~D~~ **G**.
>
> 18.In regard to Resident ~~F's~~ **G's** penile catheter failed by 20 April 2022 to ensure that:
>
> a) A care plan and/or risk assessment was in place.
>
> b) The catheter had been changed within an appropriate time.

c) There was sufficient equipment available for re-catheterisation.

Mr Kennedy submitted that in relation to charge 11, there is no information in Resident D's records which indicates they had any significant weight loss between 21 March 2022 and 31 March 2022. He submitted that however, Resident G's records do show a weight loss in that period and although there is an incorrect reference to another resident in the witness statement of Witness 1, they provide evidence which links Resident G to charge 11. He submitted that despite the incorrect resident being referred to in charge 11, the same mischief still exists, and that there remains evidence in the witness statement of Witness 1 and Resident G's records, to support the charge in respect of Resident G. He submitted that "*D*" should be substituted with "*G*", to reflect the evidence.

Mr Kennedy submitted that in relation to charge 18, the information before the panel makes reference to Resident F requiring a catheter, when in fact it should have been Resident G. He submitted that this is in accordance with the evidence before the panel, in particular the witness statements of Witness 1 and Witness 3 and Resident G's records also show that they were catheterised on 22 February 2022 and that no change was noted on 17 March 2022 and 10 April 2022. Therefore, the records relating to Resident G support charge 18.

Mr Kennedy submitted that the question of fairness and justice applies to both the NMC and you. He also submitted that the mischief behind the charges remain the same, and that he is not seeking to change the nature of the charges, but simply to change the identity of the residents. He further submitted that you were provided with the documents the NMC are relying on in advance of this hearing and the schedule of anonymity referring to the residents, during the hearing. He also submitted that the requested amendments only amounted to typographical errors.

Ms MacDermott opposed the application. She accepted that the substance of the charges remains the same but submitted that it would not be fair, or in the interests of justice, to allow the amendments at this late stage of the proceedings. Ms MacDermott referred to Article 6 of the European Convention on Human Rights and submitted that you have a right to a fair trial. Ms MacDermott submitted that since

the NMC's previous applications to amend the charges, you have given oral evidence in respect of the incidents set out in the charges and it would be unfair to you to allow the NMC "*a third bite at* [sic] *the cherry*". She also submitted that this may prejudice you as the evidence you have already provided may conflict with evidence you may wish to give in relation to the amended charges.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

Decisions and reasons on application to amend charges

The panel took into account the submissions of Mr Kennedy and Ms MacDermott. The panel rejected Mr Kennedy's submission that the errors were simply typographical. The panel accepted that although the amendments seek to change the identity of the residents, the nature of the charges and the mischief behind them remains unchanged. The panel noted that you were provided with the bundle of documents the NMC is relying on in advance of the hearing and also the schedule of anonymity of the residents during the hearing.

The panel also noted Mr Kennedy's submissions that there is evidence before it to support charges 11 and 18 in respect of another resident, namely Resident G. Although it is regrettable that the errors in drafting the charges were not identified at an earlier stage, the panel is satisfied that it is not so late in the proceedings that if the amendments were made it would result in unfairness or prejudice to you. The panel accepted that fairness includes fairness to the NMC and determined that it is in the interests of justice that the amendments be made.

Following the amendments to the charges to reflect that these relate to Resident G, you will have a further opportunity to say whether you accept or deny the charges. The panel does not consider that what you have said to date in oral evidence is likely to prejudice you. The panel noted that in making full admissions to all of the charges at the outset of the hearing, you did so on the basis that as the Registered Manager of the Home, you were responsible for ensuring oversight and governance of the Home. The panel also noted that if you deny the charges, as amended, the NMC will

be required to prove these and you will have an opportunity to give evidence to the panel again should you wish to do so.

Charges 11 and 18 as amended were read into the record and admitted by you. The panel found these charges proved by way of admission.

Your evidence on misconduct and impairment

You provided a witness statement and reflective piece, and gave extensive oral evidence to the panel at the misconduct and impairment stage.

You told the panel that you qualified as a registered nurse in September 2008 and have worked in a care environment for approximately 22 years. In 2010 you said that you became a unit manager of a care home and supported the management team with elements of quality, audit care plans, oversaw staff rotas, and worked as a nurse administering medication. In 2012, you became a deputy manager of a care home and in 2014, a registered care home manager. The care home had an electronic system for auditing and record keeping. You said that this meant you had good oversight of the care provided and could delegate tasks to specific people, generate actions and follow up on these. It also allowed senior management to have better oversight of the care provided and understand if people were struggling. You said that if there were issues, regional support was sent in to provide support. You said that there was a proper chain of management and support and if you escalated issues these would be addressed. You said that no issues were identified with your professional practice during this time.

You said that in November 2018 you took up a job as registered manager of the Home. The Home accommodated up to 54 residents at any one time. When you joined things were '*not as they seemed*', the Home was in quite a lot of disrepair, the record keeping system was paper based and the majority of the nursing staff were agency nurses or self-employed.

You covered the following topics in your evidence:

Staffing

You said that the owner frequently changed agencies, sometimes at short notice, that you had no say in this and there was no consistency with staff. You illustrated this by reference to the documents before the panel, e.g. the staff rota for the week commencing 14 February 2022, and said that out of 150 nursing hours, 143 hours were covered by agency or self-employed nurses. You said that this was challenging given the complex nature of the residents' needs, many of whom had dementia. You said that you repeatedly raised concerns about staffing, including discussing with the other managers of Lotus care homes and to your direct manager and the owner. You said that you were repeatedly reassured by your direct manager and owner that staffing issues would be addressed. You said that the amount of pay the Home offered was low and not attractive to nurses. You were repeatedly told that Lotus was arranging for international nurses to come to work at the Home but said that in your time as registered manager this never happened.

Covid-19 pandemic

You also said that the Covid-19 pandemic further affected the ability to staff the Home properly. There was a lot of resistance to the Home's policy that staff had to be vaccinated before working at the Home. You said that the pandemic '*made everything so much harder'*. You said that '*at the beginning of Covid we lost 20 residents*' and you became very upset and emotional when describing this loss and the challenges that you faced. The Home cared for dementia residents and it was difficult to keep the residents isolated and this was '*something we struggled with'*.

Staff training

You said that there was an expectation that nurses would come to the Home from the agencies trained and would only require an induction to the Home. You said that agencies did not always give full information or records of training and you often had to chase for this information. As regards employees of the Home (e.g. care assistants) there was an online training programme and these employees had a responsibility for completing training. You said that it was your responsibility to

oversee that they did complete the relevant training. You had raised with staff where they were not up to date with training and had requested that they complete this. You had also escalated this to your manager and the owner but in future you would more formally address it in supervision meetings with staff and set timelines for completion and if they failed to complete it you would involve HR, or escalate it externally, if your concerns were not addressed.

Support and supervision

You said that you had very little support and no one to one supervision during your time working at the Home. You said that the structure above you consisted of a manager who oversaw the four care homes in Lotus group and the owner. There was no deputy manager, unit manager or heads of department to support you. About one year after starting an administrator was employed to provide support. A housekeeper was responsible for managing the cleanliness of the Home and you oversaw all other departments. In summary, you said that there was no '*ladder of leadership'* or formal structure and apart from the cleanliness of the Home you were responsible for managing everything else.

Record keeping/auditing

You said that all the records, care plans, risk assessments and audits were paper based and as a result it was difficult to have proper oversight over these. You said that it was your responsibility to oversee that staff were maintaining and updating records and care plans properly and you were trying to keep up with this but you expected staff to raise specific issues or concerns directly with you. You said that in some cases you knew that staff were not properly recording the care that had been given e.g. thickeners, repositioning. You had raised the issue of better record keeping with staff at meetings and emphasised the importance of this.

You also said that you '*worked with what you knew'* or what was expected of you by the Home. You said that the Home did not have a '*tool*' for auditing and that you had put one together. You completed 30 audits each month, and generated an action plan or tasks for staff as a result of your reviews. You also did 'ad hoc' checks of

records during your daily rounds of the Home. You said that you were not aware that there was an expectation on you to complete weekly audits of controlled drugs and the auditing tool you were using required you to audit this monthly. You also said that you were not expected to review all of the residents' care plans each month but you aimed to audit these on a six-month basis or sooner if required. You said it was very difficult to keep up with the audits and follow up and during the Covid-19 pandemic the workload became excessive and at times unmanageable.

Maintenance of the Home

You said that there were two people employed to carry out maintenance across the four Lotus care homes in the area. However, one of these individuals was on long term sick leave for long periods in 2021 and 2022, which left one person to cover all the maintenance work at the homes. This made it difficult to get repairs done. You said that it was your responsibility to ensure that the maintenance checks had been done and if there were issues that these should have been reported to you. You were not aware of issues with the fire doors and none had been reported to you. You were aware of the issues with replacing the call handsets and the delays in carrying out the fire risk assessment.

You referred in particular to the difficulties you had getting a fire risk assessment of the Home done. You said that you were aware that as the registered manager it was your responsibility to ensure that the fire risk assessment was completed and you were very worried that the Home was not compliant. The fire risk assessment was due in August 2021, and you made several informal requests to get this done. You said that throughout November and December 2021 you repeatedly emailed requesting that the fire assessment be completed. On 17 December 2021, the assessment was supposed to be completed but nobody showed up. You sent further emails throughout January and February 2022, copying in your manager and the owner of the Home. You said that you believe that the reason for the non-completion of the fire risk assessment company was that there was an unpaid or outstanding invoice. You said that it had been extremely frustrating and worrying and that even after escalating to senior management the assessment was not done. Following completion of the assessment, you said that you had to repeatedly chase for the

report. You said that you think that this was provided around the time of the CQC inspection.

You also told the panel about the difficulties you had trying to get replacement call handsets. You said that you were several months chasing to get new call sets, that the system in use at the Home was very old and dated and it was difficult to get replacements as you understood that they were not being made any more. It was agreed that a new system would be installed and you made repeated attempts in February 2022 to get this done. You said that meanwhile you had asked staff to ensure that regular observations were being conducted of residents and the observation charts were completed hourly. You said that you had raised this in staff meetings.

Supporting another care home

You said that around the end of January 2022, you were asked to provide support to another home in Lotus group when the manager of that home left. You said that you had felt obligated to do this and you went to that home approximately one to two days a week for one month. You said that this was to the detriment of the Home as you still had to manage your workload at the Home without support. You said that in hindsight you understand that you should have said 'No' to this request.

CQC inspections

You said that [PRIVATE], and you were not present during the first CQC inspection. The second date of the CQC inspection, 28 March 2022, was your first day back at work. You recalled being completely overwhelmed on that day and said that people wanted you everywhere and at times multiple people were asking you for things. You said that you took the CQC inspection and requests for information extremely seriously, that you felt '*completely stressed out and overwhelmed'* and you tried to do the best you could.

You said that as a company Lotus was '*reactive'* and that '*nothing happened until something happened*.' If there was an incident an additional audit or task was

created. You said that in early 2022, shortly before the CQC inspection, you had a conversation with your manager and said that you were '*too stressed'* and '*didn't want to do the job any more'*. You said that she persuaded you to stay on and promised you additional support but '*nothing changed'*.

Reflection

You said that you understand that it was your responsibility as the registered manager to oversee the running of the Home, provide leadership to and manage the staff and ensure the requirements of the CQC regulations were met. You had worked tirelessly to try to ensure that the Home was following Covid guidance, that it had sufficient staff, to keep up with the auditing, to manage the staff, ensure good quality record keeping, to attend meetings and ensure the Home was stocked and had necessary supplies. However, you said that the lack of support for you as the manager of the Home and lack of consistent staff made it very difficult to ensure that documents and records were being completed accurately, and care plans were being followed. You now understand that you should have asked for more support, documented the concerns you had raised with senior management and ultimately more formally escalated these, including to the CQC or local authority.

You said that at the time you lacked confidence in raising your concerns externally as you feared that you would end up before your regulator as the person responsible for the failures. You said that you now understand that you should have been more assertive about saying '*No*' and documenting and escalating concerns. You said that you should have been more honest and open about how stressed and overwhelmed you felt. You feel ashamed that you did not take more action and had let residents down. You were extremely remorseful for any harm that had come to residents as a result of your failures. You recognised the impact of your failures on the profession and on the public's trust in the profession. You told the panel:

> '*They lost faith in the whole sector. They trusted me, us all, to do our best. We failed them at that. I am ashamed I've become that person…'*

You also expressed remorse at the impact on the residents of the Home and their families.

You told the panel:

> '*It's hard enough as it is to leave your loved ones and you expect them to be cared for. It's heartbreaking for them being told that their precious family hadn't been cared for in the best way…*

You said that you accept responsibility for your actions and feel that your experience has made you more conscientious in your practice. You are less eager to please and more confident to speak out. For example, if you now see a problem that you feel uncomfortable with you will request support from a colleague or additional training. If this is an issue above the scope of your role or knowledge you will escalate to the relevant person within the leadership team. If the company is unable to provide the relevant training, you would attend external training to ensure the quality of your care is up to standard. If there is an issue with medication supply or doses, you would report to the clinical lead nurse to investigate, and would also add this concern to a Datix System for investigation. If you had an issue with a staff member not performing to the best of their ability or in line with the expectations of the company, depending on the issue, you would speak to them directly or would report to the home or deputy manager via email or letter to evidence your concerns.

You said that in future, if you were to find yourself overwhelmed, you would request a suitable time to discuss this matter with your line manager, request that your concerns or issues be documented, follow up with written confirmation of what you had discussed via a letter or email. Additionally, you would request that you could discuss further once management had been able to look at a potential resolve to agree the best solution for the issue. If you continued to be unhappy with the resolve, you would escalate further following the company policy for doing so. If you were not able to escalate this further up the chain due to lack of leadership, depending on the circumstances, you would escalate any concerns to the local council safeguarding team or the CQC.

Personal circumstances

[PRIVATE]

Submissions on misconduct

Mr Kennedy invited the panel to find the facts found proved by admission amounted to misconduct.

Mr Kennedy referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311, which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious…'*

Mr Kennedy referred the panel to the terms of '*The Code: Professional standards of practice and behaviour for nurses and midwives 2015*' (the Code). He identified the specific, relevant standards where he submitted your actions amounted to misconduct. In particular, he stated that you had breached the following sections of the Code:

> **'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
> **2.1** work in partnership with people to make sure that you deliver care effectively
> **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

3.4 act as an advocate for the vulnerable challenging poor practice […] and behaviour relating to their care

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

10. Keep clear and accurate records relevant to your practice

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

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

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

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

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

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

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

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

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken.'

Mr Kennedy submitted that the NMC accepts that not all breaches aforementioned will lead to a finding of misconduct. He submitted that your behaviour fell below the

standards expected of a registered nurse and therefore, amounts to misconduct. He submitted that you are an experienced nurse and manager, and that you were in a position of authority and trust as the Home's manager. He further submitted that you had carried out your role for a number of years with no concerns, which indicates you knew how to do your job. He submitted that in your role, you failed to consistently deliver the expected high standards of quality care to the residents. He also submitted the following factors contributed to taking you over the threshold of falling short of the expected standards of a registered nurse:

- You were an experienced nurse and manager;
- You were in a position of authority as manager;
- You were entrusted with the care of vulnerable residents;
- It is the view of the CQC that you ignored or at least failed to act on concerns which were raised. You gave the impression that you didn't take them seriously;
- The matters found proved relate to areas of practice for a registered manager of a care home which are not in any way unusual; and
- Your lack of oversight led to actual harm for one resident and exposed others to a risk of harm.

Mr Kennedy referred the panel to the NMC guidance FTP-3, '*How we determine seriousness*' and FTP-12 '*Taking account of context*'. Regarding context, he said that you told the panel:

- How busy you were in the Home;
- The lack of permanent staff working at the Home;
- The lack of support you had from senior management;
- You relied on staff to do their jobs properly, and you had been let down by them;
- There was no specific requirement imposed on you by the Home to carry out certain audits or checks.

Mr Kennedy submitted that if the panel view you as a credible and reliable witness, these are important contextual matters which require consideration. Mr Kennedy also said that to your credit, you had admitted all the charges.

Mr Kennedy submitted that even when taking the matters above regarding context into account, your behaviour fell well below the standards expected of a registered nurse working as a registered care home manager and is sufficiently serious to amount to misconduct. He submitted that your lack of oversight in several areas impacted on the wellbeing of the residents under your care. He submitted that the charges found proved by admission amount to misconduct.

Ms MacDermott submitted that you escalated several concerns to senior management, and these concerns were ignored. She referred the panel to FTP-12 (and in particular, FTP-12g), and submitted that the panel should take the context around the events into consideration when deliberating on misconduct.

Ms MacDermott submitted that the environment you were working in was not a positive working environment, given the culture of the Home and that this was a contributing factor to the incidents. She submitted that you told the panel during your oral evidence that you did not feel supported. You also felt obligated to assist in managing another care home for Lotus, to the detriment of the Home. She submitted that it was clear that the Home was understaffed and overly reliant on agency staff and she referred the panel to Mr Kennedy's submissions regarding contextual factors which were relevant to your performance as a registered manager of the Home.

In relation to FTP-12g, Ms MacDermott submitted that holding one individual to account in circumstances where group norms or cultural issues may have influenced their actions or behaviours may be unfair. She submitted that where concerns were raised by you and dismissed or not responded to, it may indicate that a working environment existed which prevented you from doing the right thing.

Ms MacDermott invited the panel to find that the charges found proved do not amount to misconduct.

Submissions on impairment

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

Mr Kennedy submitted that there is a strong public interest in this matter and referred the panel to the Shipman test approved in Grant. He submitted that the three of the four limbs in Grant are engaged in this case, namely:

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. *…*

Mr Kennedy submitted that the panel would need to consider your past actions and determine whether there is a risk of repetition in the future. He referred the panel to the case of *Cohen v GMC* [2008] EWHC 581 (Admin) which says:

> *" It is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations … namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession".*

Mr Kennedy submitted that the panel will also need to consider remediation. He submitted that when the panel are deciding on whether your fitness to practice is impaired, the following factors should be considered:

- Whether the conduct which led to the charge is easily remediable;
- Whether it has been remedied; and
- Whether it is likely to be repeated.

Mr Kennedy submitted that by your admissions to the charges, you have shown some insight, and that you recognised you are not '*cut out'* for a role in management. He submitted that as written in your reflective piece, you highlight a number of factors which contributed to the NMC referral, which includes:

- Lack of permanent staff;
- Lack of support from management;
- Lack of forms for certain tasks; and
- Relied heavily on your staff to carry out their duties properly.

Mr Kennedy submitted that there was a clear lack of oversight, and that you placed too much trust in your staff. He submitted that you did not do enough to ensure that your staff were carrying out their duties to the required and expected standard. He submitted that when issues were identified and raised with you, you failed to follow through and confirm your instructions were being carried out. He also submitted that although there is some personal mitigation, this does not excuse your lack of responsibility for the welfare and safety of the residents in the Home. He submitted that there is a lack of accountability in your written statement and reflective piece and that you did not adequately address the effect the lack of oversight had on the residents. He further submitted that this was only addressed during the panel's questions.

Mr Kennedy submitted that in terms of remediation, your misconduct is remediable, and that since the events which took place two and a half years ago, you have not repeated the misconduct. He submitted that you have continued to work as a registered nurse, although not in a managerial position. He further submitted that you told the panel you have no intention of returning to a managerial position. He referred the panel to the positive testimonials, appraisals and training certificates in

your bundle, and submitted that these show a degree of remediation. However, he submitted that you have not produced evidence that you are able to work safely and effectively as a Home Manager. He submitted that without this evidence, there remains a risk of repetition of the behaviours found proved.

Mr Kennedy submitted that your lack of oversight put the residents at unwarranted risk of harm and in some cases, actual harm was caused to residents. He submitted that you have brought the profession into disrepute given the seriousness of the conduct and that you have breached the fundamental tenets of the nursing profession. He submitted that this is not the type of behaviour which the public or other colleagues would expect from a registered nurse in a managerial position. He further submitted that there is a need to maintain public trust and confidence in the profession, the NMC as its regulator and uphold the proper standards. He submitted that a finding of impairment is required on the grounds of public protection and the wider public interest.

Ms MacDermott submitted that you have demonstrated significant insight into your conduct, and that you have provided the panel with a very detailed reflective piece. She submitted that since the incidents, you have reflected deeply on the issues and recognised what went wrong. You have taken personal accountability and accepted full responsibility, and although you have provided the panel with important information on context, you have not sought to blame others for what went wrong.

Ms MacDermott submitted that you have identified a tendency to *'people please'* and although you raised concerns with management, and followed up on these, you now recognise you were not assertive enough. Ms MacDermott submitted that you now understand that you needed to do more to speak up. She referred to the example you had given in oral evidence of where you had spoken up in your current role as a registered nurse when something was not right. You had identified a significant issue with regards to paperwork not completed correctly, you had raised it with the Clinical Lead and you had also rectified the matter. She submitted that although this was in the context of working as a registered nurse, it demonstrated that you had applied the learning and insight you had gained from what had gone wrong at the Home. She submitted that you were not at risk of repeating the conduct found proved.

Ms MacDermott further submitted that the panel did not need to find impairment on the grounds of public interest. She submitted that the NMC investigation and regulatory process was sufficient to maintain trust and confidence in the profession and the NMC as its regulator, and that the standards required could be upheld if a finding of impairment was not made on public interest grounds.

Ms MacDermott invited the panel to find your fitness to practice was not impaired on either public protection or the wider public interest.

Decisions and reasons on misconduct

The panel heard and accepted the advice of the legal assessor.

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

The panel took into account the submissions of Mr Kennedy and Ms MacDermott.

The panel carefully considered the NMC guidance '*Misconduct FTP-2a'*. The panel was satisfied that this is a case which involves you, a registered nurse, acting as a registered manager of a care home. The panel was satisfied that although you were not providing direct care to individuals, you were undertaking activities closely related to your professional practice, as the registered manager of the Home. The panel noted that the CQC inspection report on the Home, dated 25 August 2022, stated the following:

> *'Registered Manager*
> *…A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.'*

The panel noted that the CQC report made the following findings in relation to the registered manager of the Home, in the section '*Well led'* which looked at service leadership, management and governance:

- '*The provider and registered manager failed to ensure the service was consistently well-led. There was a lack of quality assurance, therefore shortfalls found at this inspection were not already known or suitably acted on.'*
- *'The provider and registered manager failed to ensure compliance with regulatory standards, including environment safety, risk assessment and mitigation, medicines management, person centered care, nutrition and hydration, staffing and infection control processes. This had resulted in people had* [sic] *being exposed to the risk of avoidable harm.'*

In considering the NMC guidance on '*Misconduct',* the panel noted in particular the following:

> *'…When we are looking at safety incidents which relate to people receiving care involving nurses, midwives or nursing associates, we will always look carefully at the context in which they were practising. Even poor practice by a nurse, midwife or nursing associate might actually have happened because of underlying system failures.*
> *In these circumstances, taking regulatory action against a nurse, midwife or nursing associate may be unfair, and may not stop similar incidents happening again in the future or keep people safe…'*

The panel noted that the CQC report identified an overreliance by the Home on agency staff. Staff recruitment and inconsistent nursing staff were a significant factor in relation to the failures identified in the CQC report. You told the panel that you repeatedly escalated your concerns regarding staffing and these had never been properly addressed by management. You also told the panel that you were not supported by management and that other issues you escalated were not acted upon, for example, the fire safety inspection and the issues with the call handsets.

Save as detailed below in respect of the charges, the panel determined that your actions fell short of the standards expected of a registered nurse, employed as the registered manager of the Home. The panel carefully considered the Code and concluded that your actions amounted to breaches of the following sections:

‘8.5 Work with colleagues to preserve the safety of those receiving care

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

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

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

20.1 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

25.2 Support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken.’

The panel appreciated that a breach or breaches of the Code do not automatically result in a finding of misconduct. In assessing whether the charges amounted to misconduct, the panel considered the charges individually and collectively as well as the circumstances of the case as a whole. For ease, the panel has grouped the charges according to the different areas of concern.

The panel found you to be a credible and reliable witness. It took into account your oral evidence which you gave in a frank and open manner. You did not seek to blame your employer or other staff for your failures and as the registered manager of the Home, you accepted full responsibility for the matters set out in the charges. You clearly described the context in which you were working and the challenges you faced. The panel determined that you did not attempt to embellish your evidence or hide behind your employer.

Regarding your personal circumstances at the time, the panel was of the view that you did not seek to use these as an excuse for your failings, and it was only made aware of your difficult personal circumstances when [PRIVATE].

Charge 23

The panel determined that this incident was not a serious failure amounting to misconduct. It considered that it was one incident involving one resident, who had not been isolated appropriately via the expected process or guidelines. You told the panel that Resident H had been discharged from hospital during the night without your knowledge and you had not found out about it until the following morning. The panel has also seen information from the CQC inspection notes which says that the registered manager was unaware that Resident H was being returned to the Home until she arrived for duty in the morning. You said that the staff working at the Home should have made contact with you as you were on call and you had spoken to them about this after the incident. You said that the resident had been tested before returning to the Home and had tested negative for Covid. However, you accepted that the resident should have been isolated on return to the Home and that had not happened.

The panel accepted your evidence that Covid-19 guidelines were in place in the Home at the time for staff, and were clearly displayed on the infection control board, but that there was a failure by the staff on duty that evening to follow the guidelines. The panel determined that in the circumstances, the failure to ensure that Resident H was isolated from other residents on return from hospital was not so serious that it amounted to misconduct.

Charge 24

The panel determined that based on the information before it, a failure to ensure the handover record for Resident H indicated that the resident had in place a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was not so serious that it amounted to misconduct. Information about this incident is set out in the CQC inspector's notes. These say that at 11:00 a senior care assistant handed the CQC inspector a DNACPR document which had been left on an office desk and not filed when Resident H had returned from hospital during the night. The CQC notes report that consequently the resident's records had not been updated to say that they were not for resuscitation. The panel noted that although this was not best practice, Resident H had only recently returned from hospital and you had only found that out on arrival for work that morning. Also, the CQC inspection was ongoing and your evidence was that you were extremely busy dealing with requests from the CQC for information and would not have had time to check or ensure that everything was in order with Resident H's return. The panel determined that this failure was not so serious as to amount to misconduct.

Charges 4a, 4b and 4c

The panel noted that the fact that Resident B had not been administered medications when due is a serious matter. The panel considered the evidence before it and determined that the medications were out of stock at the time, so Resident B could not have been given them. The panel also took note of your oral evidence, when you stated that it would have been the responsibility of the nurse in charge of Resident B to ensure that medications were ordered. You accepted that you had overall responsibility to ensure this was done. You would do this by way of medication

audits and checking residents' records. The panel noted that you [PRIVATE], and had to rely on staff to ensure that medications were being ordered as required. The panel determined that you would not have had sufficient opportunity on your return to work to identify the failure in respect of one resident, namely Resident B, given the short timeframe between the incidents and the failure being raised and identified to you by the CQC. Therefore, the panel determined that this failure to ensure that Resident B received their prescribed medications did not amount to misconduct.

Repositioning

Charge 12

The panel noted that this failure related to one resident and occurred on one date i.e. 31 March 2022. The panel also noted that the context in which this failure occurred, namely, that you had recently returned from [PRIVATE], and you were extremely busy responding to requests for information from the CQC. The panel considered that although it was not best practice, a failure on one date to ensure that a resident was repositioned in a timely manner was not so serious as to amount to misconduct.

Falls

Charges 32a and 32b

The panel took account of the evidence before it and determined that there was insufficient evidence to determine that your failures in respect of Resident K were serious enough to amount to misconduct. The panel noted that it did not have any records for Resident K. The information in relation to these charges came solely from the CQC inspection documents, which lacked details including the dates on which Resident K had further falls.

You told the panel that you did not recall specific details of Resident K's fall and you noted from the charge that Resident K's unwitnessed fall happened on 18 March 2022. You said that this date fell on a Friday and you would not have been working in the Home at the weekend. You said that [PRIVATE].

It was not clear to the panel from the information provided that you had been made aware of Resident K's fall on 18 March 2022, or their subsequent falls. The panel acknowledges that falls involving vulnerable residents are always serious. However, in respect of charge 32a, the panel considered that as the fall occurred at an undocumented time on Friday 18 March 2022 and that you were [PRIVATE] from the following Tuesday you had insufficient opportunity to ensure that guidance was being followed. In respect of charge 32b, the panel had no evidence before it as to when these occurred. The panel was not satisfied that in the circumstances that this amounted to misconduct.

Doors in residents' rooms

Charge 35

You told the panel that you were not aware of any issues with the doors in the residents' rooms until the CQC brought it to your attention. You said that refurbishments were ongoing and your understanding is that the strip inside the door had been painted over and this is the reason why the doors did not close. Nobody had brought this to your attention. You said that it was the maintenance workers' responsibility to ensure that checks were carried out, and you were relying on the maintenance workers to update you. You also talked in detail about the difficulty in getting the fire risk assessment completed and obtaining the subsequent report. You said that you were not sure when you received the report but believed it to be around the time of the CQC inspection. The panel determined that although you accepted you failed to ensure that doors in the residents' rooms were able to fully close, in the circumstances, this was not a serious falling short of the standards expected of a registered nurse, working as a registered manager and did not amount to misconduct.

Medications audit

Charge 38

You told the panel that the Home required you to carry out monthly audits of controlled drugs. You said that you now accepted that you should have carried out weekly audits in line with CQC guidelines, but at the time you did not know this and accepted that was a gap in your knowledge. You told the panel that you should have known about this requirement. The panel noted that you were conducting audits of controlled drug stock, albeit on a monthly, rather than weekly basis. The panel determined that this was an oversight, rather than a deliberate omission on your part. The panel was not satisfied that in the circumstances, this amounted to a serious falling short of the standards expected of a registered nurse, working as a registered manager and determined that it did not amount to misconduct.

Medication administration

Charges 21a, 21b, 26a, 26b, 27 and 28

The panel looked at each of these charges individually which all related to your failure to ensure that residents were administered medication. The panel noted that the failures occurred over a period spanning February to April 2022 and involved a number of residents on multiple occasions. The panel determined that these residents were vulnerable, and you were responsible for the quality of care provided. The failures to ensure that the residents were receiving their medication were very serious and a significant falling short of the standards expected of a registered nurse, working as a registered care manager. The panel also determined that individually and collectively your failures in respect of these charges were serious and amounted to misconduct.

Weight loss

Charges 3a and 3b, 5a, 5b, 11a, 11b, 16a, 16b, 30a and 30b

The panel carefully considered each of these charges individually. The charges all related to failures in the care of residents who experienced weight loss. These included failures to ensure that residents:

- Were referred to dieticians at all or in a timely manner;
- Care plans, or risk assessments were updated; and
- Food and/or fluid charts were adequately recorded or being followed.

The panel determined that these failures were serious and involved elderly and vulnerable residents, who were losing weight, sometimes rapidly. Resident I was entirely dependent on PEG feeding, and the panel saw evidence that they had lost 5kg in four weeks after being admitted to the Home, and no steps were taken to prevent further weight loss.

The panel noted that the failures occurred over a period spanning September 2021 to April 2022 and involved five residents. The panel determined that these residents were vulnerable, and you had overall responsibility for the quality of care provided to them. The failure to ensure that the residents' weight loss was appropriately managed was a serious falling short of the standards expected of a registered nurse, working as a registered care manager and amounted to misconduct. The panel determined that individually and collectively your failures in respect of these charges amounted to misconduct.

Equipment (catheter, nebuliser)

Charges 18a, 18b and 18c

The panel took into account the evidence in relation to charges 18a, 18b and 18c, which was in relation to Resident G's catheter. It noted the CQC report, where it states:

> '…*A senior nurse reviewed a person's catheter care plan and risk assessment, they failed to acknowledge the catheter had not been changed as prescribed and was five weeks delayed exposing them to the risk of infection…'*

The panel determined that your failures to adequately ensure that Resident G had a care plan or risk assessment in place, that their catheter had been changed within an appropriate time and that there was sufficient equipment available were serious. The panel noted that there had been a five-week delay in changing the catheter, which exposed Resident G to a risk of infection. The panel determined that your actions fell short of the expected standards of a registered nurse, working as a registered care manager and your omissions amounted to misconduct.

Charge 25

Resident I's nebuliser – the panel took into account the witness statement of Witness 3, where they state:

> *'…As Miss Sullivan had overall responsibility of the Home as the Home Manager, they were responsible for admitting residents and ensuring the Home had all necessary equipment in place to ensure the resident received adequate care. This would be set out in Miss Sullivan's job description, and from their duties as being the Registered Manager.*
>
> *This is also very serious concern. Resident I could have potentially died if they were unable to receive their medications, or faced an increased risk becoming unwell with chest infections on* [sic] *pneumonia…'*

The panel noted that in your evidence, you said that you did not have the overall say in who was admitted to the Home and had to accept residents that were sent to you, regardless of their acuity. You told the panel that you could not clearly remember this incident. However, you said that you had not been made aware that this equipment was outstanding. You said that as the registered manager, with overall responsibility for Resident I's care, you accepted this failure.

The panel determined that as you were the registered manager of the Home, it was your responsibility to ensure that the Home had all necessary equipment in place to ensure Resident I received safe and adequate care. The panel noted that this failure put Resident I at a serious risk of harm. The panel determined that this was a serious

falling short of the standards expected of a registered nurse, employed as a registered manager and therefore amounted to misconduct.

Wound care management

Charges 15, 17 and 20

You told the panel that you were aware that some residents in the Home had wounds. The panel determined that there was a serious failure in oversight in providing wound care to the residents under your care. The panel noted that these charges involved three residents whose wounds had not properly been managed. The panel determined that your failure in oversight is likely to have caused harm to these residents.

The panel concluded that your failures amounted to a serious falling short of the standards expected of a registered nurse, working as a registered manager of the Home. The panel therefore found that individually and collectively, these failures amounted to misconduct.

SALT

In regard to Residents A, C, D and I,

Charges 1a, 1b, 6a, 6b, 9 and 29

The panel carefully considered these charges individually. The panel noted that there were failures to ensure that residents' foods and/or fluid were in line with their SALT assessments, and that care plans had been updated.

The panel noted that there was a significant risk of aspiration, pneumonia, and choking as a result of these failures, and that residents were put at risk of harm. It took account of Witness 3's witness statement:

'*…These are very serious concerns, as not following the SALT referrals can have catastrophic consequences on the resident if they are not follows, for example they risk taking liquid directly into the lungs, risking aspiration, pneumonia, and possibly death…*'

The panel noted that these failures involved four residents between October 2021 and April 2022. The panel determined that your failures were serious and fell short of the standards expected of a registered nurse, working as a registered manager. The panel determined that, individually and collectively, your failures amounted to misconduct.

Food and fluids

Charges 2, 7a, 7b, 8a, 14, 19 and 33

The panel carefully considered these charges individually. The panel noted that there were failures to ensure that food and fluids were recorded or monitored appropriately, that their fluids care plans accurately reflected their needs, and residents' daily fluid targets were reached. The panel noted that the CQC had multiple concerns in relation to monitoring, recording and ensuring residents were being given sufficient fluids. The panel determined that this was serious, and accepted there was a potential risk of harm to residents, including the following:

- Dehydration
- Heart failure – in the case of Resident L;
- Low fluid intake;
- Urinary Tract Infections (UTIs); and
- Confusion

The panel took into account Witness 3's witness statement, which commented on the CQC report:

'*… with respect to Resident D in which a SALT assessment, dated 22 October 2021, prescribed Resident D level 2 thickened fluids and level 4 puree meals. Miss Sullivan would have been aware of this through the handover sheet…However, the diet and fluid records for Resident D showed that foods had been given to Resident D which were not thickened as per their SALT referral…*

…Resident A was assessed to require level 2 thickened fluids, and Ms Sullivan would have been aware of this…the Home was made aware of the SALT referral in an email (which would have been received by the Home Manager) on 25 February 2022, but on 11 April 2022 (during the inspection) the CQC found a jug of juice in Resident A's bedroom which had not been sufficiently thickened. This is not referenced in Resident A's records…

…It is the responsibility of the nursing staff to feed residents and provide them with fluids. However, Miss Sullivan as the Home Manager and a Registered Nurse, has responsibility for overseeing the clinical care provided at the Home, and addressing any issues in the records such as weight loss or fluid intake.

Miss Sullivan should have completed monthly audits to ensure care staff were meeting each residents' needs, and if there were shortfalls (as seen above) Miss Sullivan should have addressed this directly with staff to ensure there was an improvement…'

The panel noted that these charges involved five different residents, in March/April 2022. It concluded that these failures in oversight were serious and fell significantly short of the standards expected of a registered nurse, working as a registered manager. The panel concluded that these failures, individually and collectively, amounted to misconduct.

Training and supervision of staff

Charges 31, 36, 39a and 39b

The panel took into account your evidence in relation to the training and supervision of staff. There was sufficient evidence that there was a lack of training and oversight from you. The panel had sight of staff training records which demonstrated that not all staff were up to date with mandatory training, including fire safety training. The panel accepted that you had made some efforts to ensure staff were completing their training in a timely manner by raising this directly with the staff and putting notices and reminders up in the Home. The panel noted that in your oral evidence you said that you could have done more, including setting deadlines and escalating to HR.

The panel considered that the failure to ensure that staff were trained in and or using safe moving and handling techniques, had the potential to result in harm to residents and staff.

A failure to ensure that all staff had up to date fire safety training put residents, staff, and visitors to the Home at risk of harm in the event a fire broke out. The panel determined that although you made some efforts to ensure staff competed mandatory training, these were insufficient in that all staff were not trained fully in the required areas. The panel determined that your failures were serious and fell short of what was expected of a registered nurse, working as a registered manager, and amounted to misconduct.

PEEPs – Personal Emergency Evacuation Plans

Charges 34

The panel considered all of the evidence before it, and noted an extract from the CQC inspection document:

> '…[PRIVATE] *found 16 Personal Emergency Evacuation Plans (PEEPS) with incorrect information or not in place. PEEPS had not been reviewed since 08/11/2020, therefore information available in the case of an emergency evacuation was incorrect and would jeopardise a timely response from emergency services…'*

The panel noted the risks outlined above and accepted vulnerable residents and staff would not know what to do in the event of a fire. The panel noted that the failures related to 16 PEEPS, and that these had not been reviewed for approximately 17 months. The panel determined that this was a serious falling short of the standards expected of a registered nurse, working as a registered manager and this amounted to misconduct.

Decisions and reasons on impairment

In coming to its decision, the panel had regard to the Impairment guidance (DMA-1), updated on 3 March 2025, which states:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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 always justifies both their patients' and the public's trust in the profession.

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

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper*

professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) *…'*

Applying the above test and looking to the past, the panel determined that limbs a, b, and c were engaged. As the Registered Manager of the Home, you had overall responsibility for the quality of care provided to vulnerable residents. The panel noted that it found multiple failures in respect of your oversight of key aspects of residents' care including wound care management, weight loss, provision of food and fluids, SALT assessments, medication administration and provision of appropriate medical equipment, which put residents at unwarranted risk of harm.

The panel determined that your conduct as Registered Manager of the Home breached the fundamental tenets of the nursing profession and fell seriously short of

the conduct expected of a registered nurse. You failed to ensure that vulnerable residents in the Home received the quality and standard of care expected, and your conduct has brought the profession into disrepute.

The panel applied the Shipman test and looked to the future when considering whether your fitness to practise is currently impaired. The panel asked itself three questions. Firstly, whether your misconduct is easily remediable. Secondly, whether you have strengthened your practice so as to remediate your misconduct. In this regard, the panel considered the quality of your remorse, whether you have shown sufficient insight into your misconduct and any relevant training that you have undertaken since these incidents. Thirdly, having considered the first two questions, whether your misconduct is highly unlikely to be repeated.

The panel determined that your misconduct is easily remediable. The misconduct in this case centres around a lack of effective oversight and governance, in your role as Registered Manager of a care home, rather than your clinical skills as a registered nurse. The panel has not found any deep-seated attitudinal concerns or any possible failures relating to a duty of candour. The panel was therefore satisfied that the misconduct is easily remediable.

The panel has carefully considered all of the evidence before it. The panel noted that you made full admissions at the outset of the hearing to all of the charges. You did not seek to blame others or hide behind others (the manager and/or owner of the Home), or use your difficult personal circumstance as an excuse. The panel noted from the CQC report that there were numerous systemic failures identified on the part of the '*provider*', including in relation to staffing, recruitment and training, systems and processes to safeguard residents and using medicines safely.

The panel, having assessed your lengthy sworn oral evidence, accepted that you were extremely remorseful for the impact your failures had on the residents in the Home and their families. It noted that when giving evidence about the impact on the residents, you became demonstrably upset. The panel accepted that you were deeply ashamed of your behaviour, and that you cared for the residents, who were extremely vulnerable, some of whom suffered from dementia.

In your oral evidence, you told the panel that you recognised the impact of your failures on the profession and on the public's trust in the profession. You told the panel:

> '*They lost faith in the whole sector. They trusted me, us all, to do our best. We failed them at that. I am ashamed I've become that person…'*

The panel found that you were genuinely remorseful for your failures.

The panel next considered your insight into the misconduct found proved. The panel gave careful regard to the NMC guidance '*Has the concern been addressed – FTP-15b'.*

In relation to the above guidance, the panel noted that a nurse who shows insight will usually be able to:

- *'Step back from the situation and look at it objectively*
- *Recognise what went wrong*
- *Accept their role and responsibilities and how they are relevant to what happened*
- *Appreciate what could and should have been done differently*
- *Understand how to act differently in the future to avoid similar problems happening*.'

The panel is satisfied that you have genuinely reflected on your failures and that you accepted the concerns when they were first raised by the CQC. You have shown significant insight into your failures. The panel is satisfied that you understand that it was your responsibility as the Registered Manager to oversee the running of the Home, provide leadership to and manage the staff and ensure the requirements of the CQC regulations were met. The panel noted that you had repeatedly raised concerns with the owner and manager and had worked tirelessly to try to ensure that the Home was following Covid guidance, that it had sufficient staff, to keep up with the auditing, to manage the staff, ensure good quality record keeping, to attend

meetings and ensure the Home was stocked and had necessary supplies. The panel acknowledged that the lack of support for you as the Registered Manager of the Home and lack of consistent staff made it very difficult to ensure that documents and records were being completed accurately, and care plans were being followed. The panel is satisfied that you now understand that you should have asked for more support, documented the concerns you had raised and ultimately more formally escalated these, including to the CQC or local authority.

The panel noted that in your reflection, you said that at the time you lacked confidence in raising your concerns externally as you feared that you would end up before your regulator as the person responsible for the failures and that residents would have to be rehomed. The panel accepted that you now understand that you should have been more assertive about saying '*No*' and documenting and escalating concerns, including externally.

The panel noted in your evidence, you said that you should have been more open about how stressed, overwhelmed and unsupported you felt as Registered Manager. The panel accepted that you understood the importance of a good support structure and leadership, which responded to concerns in a timely manner. In your reflection dated October 2024, you said:

> *'If I was able to go back, I feel I would be more honest about how the increased work load was to much, ask for more support and better evidence the support requested as well as ensure my own documentation better evidenced areas of concern and how I addressed these actions, this should include how I would escalate the issues and what actions I would take to safeguard the service in the immediate instant. Although I did request support at* [the Home]*, I know that I could have evidenced the requests better. I also should have been asking for my supervision be completed, a place I could have raised and discussed these matters with my line manager. I admit it was naive of me to believe that just a verbal conversation was enough, and I realise now I should have made sure to follow up any conversation with a message or email. This is something I ensure I do within my current day practice'* [sic]

The panel was satisfied that if you found yourself in a similar situation in the future, you would act differently. The panel was satisfied that you would be more assertive in formally documenting and escalating your concerns, including to an external organisation, if necessary. The panel considered that you now know the value and importance of a good support structure and leadership team around you.

Having carefully considered your evidence, the panel decided that through your significant insight, you have now effectively addressed the concerns and clearly demonstrated that your failings have been objectively understood, appreciated and tackled.

The panel had regard to the training certificates and information that you provided in October 2024 and your oral evidence where you said that you were up to date with all mandatory training. The panel also noted that you have been nominated for a '*Striving for Excellence'* award in your current role*.* However, the panel considered that the concerns did not relate to your clinical practice and acknowledged that it is difficult to fully strengthen practice through training in the role of a Registered Manager of a care home.

The panel next considered the risk of repetition of the misconduct found proved. The panel has found that you have demonstrated genuine remorse and sufficient insight into your misconduct. The panel took into account that you have been working as a registered nurse since 2022 in a '*neuro rehabilitation centre',* without any concerns. You provided several positive testimonials, including testimonials from your Service Manager, Deputy Manager, Clinical Lead and two Occupational Therapists at your current employer. All speak highly of you as a professional nurse, who is compassionate, committed, reliable, proactive and provides excellent care for patients. The testimonial from your manager noted that although you do not work in a managerial position, and are not responsible for establishing procedures, you take part in staff meetings where errors are discussed and have shown an understanding of processes that need to take place in case of error. It also took into account your oral evidence in your current role where you had identified a failure to update patient

records. You told the panel that you escalated this concern promptly to a manager and dealt with it, updating the relevant information yourself.

The panel also noted that you had worked for several years as a Deputy Manager and a manager of a care home prior to November 2018, without any regulatory concerns or disciplinary action. The panel, having heard all of the evidence, could not identify anything which may suggest a deep-seated attitude affecting care.

The panel determined, in all the circumstances that you are highly unlikely to repeat your misconduct and that you are therefore not currently impaired on the grounds of public protection.

The panel has determined that the misconduct found proved was serious. In these circumstances, the panel decided that a finding of impairment is needed to uphold proper professional standards and conduct and to maintain public confidence in the profession. The panel therefore concluded that your fitness to practise is impaired in the wider public interest.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of three months without a review. 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.

Submissions on sanction

Mr Kennedy informed the panel that in the original 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

revised its proposal and considered that a 6-month suspension order without a review is more appropriate in light of the panel's findings.

Mr Kennedy submitted that a caution order would not be appropriate in this case as the panel found that your misconduct was serious.

Mr Kennedy submitted that a conditions of practice order is also not appropriate in this case. He submitted that whilst you have taken steps to strengthen your practice, this is a case which relates to your failings in a managerial role.

Mr Kennedy therefore submitted that temporary removal from the register is the only appropriate and proportionate sanction to mark the seriousness of your misconduct, and to satisfy the wider public interest.

Mr Kennedy therefore invited the panel to impose a 6-month suspension order without a review.

Ms MacDermott submitted that given the panel's finding that your fitness to practise is impaired on the ground of public interest only, there is no risk to patients or the public. She therefore submitted that a caution order would be sufficient to meet the public interest in this case. Ms MacDermott submitted that the longer the caution order is imposed for, the more it would mark the severity of the underlying allegations.

Ms MacDermott submitted that if the panel determines that a more serious sanction is appropriate and proportionate, a conditions of practice order would be sufficient. She submitted that you have been working subject to an interim conditions of practice order for the last three years with no complaints raised.

Ms MacDermott submitted that you do not demonstrate deep-seated attitudinal problems and that there is no evidence of general incompetence in this case. She submitted that you have demonstrated a willingness to respond positively to retraining and have demonstrated insight in respect of the misconduct. She submitted that patients will not be put in direct or indirect danger as a result of any

conditions imposed, and that conditions would protect patients during the period they are in force.

Ms MacDermott submitted that to suspend you would have a disproportionate impact on the nursing profession and would deprive the public of a very much needed skill set that you can provide. [PRIVATE].

Ms MacDermott therefore invited the panel to impose a caution order.

In response to panel questions, the panel was informed that [PRIVATE]. You also informed the panel about the specialist skill set you have regarding caring for tracheostomy patients and the importance of this in your current role.

The panel accepted the advice of the legal assessor.

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:

- A pattern of misconduct over a period of time
- Conduct which caused actual harm to vulnerable patients and put other patients at risk of suffering harm

The panel also took into account the following mitigating features:

- Full admissions at the outset of the hearing

- Evidence of remorse and insight and steps taken to address the concerns
- Personal mitigation – [PRIVATE]

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the misconduct, in that vulnerable patients were caused harm, and also put at risk of suffering harm, 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 misconduct found proved. 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, in particular:

- *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 considered that the concerns in this case do not relate to your clinical practice, but instead relate to your failings in a managerial capacity. The panel therefore determined that there are no practical or workable conditions that could be formulated, given the nature of the concerns in this case.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel was satisfied that in this case, all of the above factors are present and the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, including that it had found impairment on the ground of public interest only, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause you, in particular that it is likely to cause [PRIVATE]. However, the panel was satisfied that any hardship caused to you is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the

profession a clear message about the standard of behaviour required of a registered nurse acting as a registered manager of a care home.

The panel determined that a suspension order for a period of three months without a review was appropriate in this case to mark the seriousness of the misconduct and to satisfy the public interest. The panel took into account Mr Kennedy's submission that a suspension order for a period of six months without a review would be appropriate in these circumstances. However, the panel determined that six months would be disproportionate in this case, as it would deprive the public of the services of an otherwise skilled nurse, be likely to cause [PRIVATE], and is unnecessarily long.

In accordance with Article 29 (8A) of the Order the panel may exercise its discretionary power and determine that a review of the substantive order is not necessary.

The panel noted that this suspension order is imposed having found your fitness to practise currently impaired in the public interest only. The panel was satisfied that the three-month suspension order without a review will satisfy the public interest in this case and will maintain public confidence in the profession(s) as well as the NMC as the regulator. Further, the suspension order will declare and uphold proper professional standards. Accordingly, a review of the order is not necessary, and the current suspension order will expire at the end of the period of suspension.

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 interests until the substantive suspension order takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Mr Kennedy informed the panel that the NMC does not intend to make an application to impose an interim order to cover the 28-day appeal period as the panel found your fitness to practise impaired on the ground of public interest only.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is not necessary in the public interest. The panel had regard to the reasons set out in the earlier parts of this determination. It considered that there was no justification for extending the period of suspension for a further month. It also considered that it was not in the public interest as it may have a chilling effect on your right to appeal.

If no appeal is made, the suspension order will come into effect 28 days after you are sent the decision of this hearing in writing.

This will be confirmed to you in writing.

That concludes this determination.