Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday, 23 September 2024 - Monday, 30 September 2024
Thursday, 24 October 2024 and Friday, 25 October 2024
Monday, 17 February 2025 and Wednesday, 19 February 2025
Thursday, 20 February 2025 and Friday, 21 February 2025
Monday, 3 March 2025 and Monday, 10 March 2025 and Wednesday, 12 March 2025
Monday, 17 March 2025 and Wednesday, 19 March 2025 – Thursday, 20 March 2025
Monday, 2 June 2025 – Friday, 6 June 2025

Virtual Hearing

Name of Registrant:	**Giorgiana Hilda Petcu**
NMC PIN:	14H0024C
Part(s) of the register:	Nurses Part of the Register- Sub Part 1 RN1: Adult Nurse, Level 1 (1 August 2014)
Relevant Location:	Nottinghamshire
Type of case:	Misconduct
Panel members:	Nicola Dale (Chair, lay member) Pamela Campbell (Registrant member) Margaret Jolley (Lay member)
Legal Assessor:	Ian Ashford-Thom (20 - 21 February 2025, 3 March 2025, 10 March 2025, 12 March 2025, 17 March 2025, 19 – 20 March 2025 and 2 - 6 June 2025) Simon Walsh (30 September 2024, 24 October 2024 and 25 October 2024)
Hearings Coordinator:	Samantha Aguilar (23 September 2024 - 30 September 2024, 20 - 21 February 2025, 3 March 2025, 10 March 2025, 12 March 2025, 17 March 2025, 19 – 20 March 2025 and 2 - 6 June

	2025) Hanifah Choudhury (24 October 2024 - 25 October 2024) Clara Federizo (17 February 2025 and 19 February 2025)
Nursing and Midwifery Council:	Represented by Arran Dowling-Hussey, Case Presenter (23 - 27 September 2024, 24 - 25 October 2024, 17 February 2025, 19 - 21 February 2025, 3 March 2025, 10 March 2025, 12 March 2025, 17 March 2025 and 19 – 20 March 2025) Represented by Matthew Cassells (30 September 2024) Represented by James Edenborough (2 – 6 June 2025)
Mrs Petcu:	Present and represented by Thomas Buxton, instructed by the Royal College of Nursing (RCN)
Facts proved by way of admissions:	Charges 2(i)(a), 2(i)(b), 2i(c), 4(vii) and 5(ii)(b)
Facts proved:	Charges 1(i), 1(iv), 1(v), 1(x), 3(iii), 3(vi), 4(iv)(a), 4(iv)(b), 4(x)(a), 4(x)(b), 4(x)(c), 4(x)(f), 4(x)(i), 4(x)(k), 4(x)(l), 4(x)(p), 5(i)(a), 5(i)(c), 5(ii)(a) 5(ii)(c) (partially proved), 5(ii)(d), 5(iii), 6(ii), 7(ii), 7(iii)(b), 7(iii)(c), 7(iii)(d), 7(iii)(g), 7(iii)(h), 7(iii)(i), 7(iii)(k), 8(iii) and 14
Facts not proved:	Charges 1(ii), 1(iii), 1(vi), 1(vii), 1(viii), 1(ix), 2(i)(d), 2(ii)(a), 3(i), 3(ii), 3(iv), 3(v) 4(i), 4(ii), 4(iii), 4(v), 4(vi), 4(viii), 4(ix), 4(x)(d), 4(x)(e), 4(x)(g), 4(x)(h), 4(x)(j), 4(x)(m), 4(x)(n), 4(x)(o) 4(x)(q), 5(i)(b), 6(i), 6(iii), 6(iv), 7(i), 7(iii)(a), 7(iii)(e), 7(iii)(f), 7(iii)(j), 7(iii)(l), 7(iii)(m), 8(i), 8(ii), 8(iv), 9, 10, 11, 12(a), 12(b) and 13.
Fitness to practise:	Impaired (on public interest ground only)
Sanction:	**Caution order (5 years)**

Interim order: **N/A**

Application to redact hearsay evidence

The panel heard an application made by Mr Buxton on your behalf, under Rule 31 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended ("the Rules"), to redact hearsay evidence contained within Witnesses 1, 2, 3 and 4's evidence.

Paragraph 16c of Witness 1's statement to the NMC

Mr Buxton submitted that paragraph 16c of Witness 1's statement dated 31 August 2021 which starts with the line, *'A staff member* […] *described to me'*. He informed the panel that the statement was made in your absence and the residents referred to are not specified in any of the charges. Therefore, he submitted that this is not relevant in the context of the charges and the people who made those assertions are not available or present to be challenged. In terms of the staffing numbers and the dependency tool, he submitted that there are at least two witnesses who can give evidence in relation to that.

Paragraph 33 of Witness 1's statement to the NMC

Mr Buxton submitted that the sentence which starts with, *'Resident G reported that staff were* […]*',* is hearsay. The Resident in question is not available, and there has to be some doubt as to the reliability of any account given as this was a patient who was living with dementia and who was noted to be quite challenging.

Paragraph 44 of Witness 1's statement to the NMC

Mr Buxton submitted that the final sentence of this paragraph which starts with, *'*[…] *explained…',* contained opinions and comments which are incapable of challenge in respect of which no attempt appears to have been made to obtain a witness statement. He submitted that for that reason, it would be unfair in the circumstances to admit that paragraph.

Paragraph 47 of Witness 1's statement to the NMC

Mr Buxton submitted that in this paragraph, a member of staff has been named but no statements have been taken either locally or within these proceedings. Accordingly, he submitted that this is hearsay and not capable of challenge.

Paragraph 19 of Witness 2's statement to the NMC

Mr Buxton submitted that in respect of Witness 2's statement to the NMC dated 24 May 2022, there are references made to the opinion of a BKR Care Consultancy ("BKRCC") consultant and the reported statement of a staff member who is not due to attend these proceedings. Mr Buxton specifically referred to the section of this paragraph that starts with, *'I asked* […] *for a second opinion…'* and through to the end of the paragraph. Mr Buxton submitted that it would be improper and unfair to admit that evidence. Witness 2 and perhaps others, can give evidence in respect of Resident H separately.

Paragraph 38 of Witness 2's statement to the NMC

Mr Buxton submitted that the sentence starting, *'*[…] *mentioned the GP…'* within this paragraph refers to the reported statement from a BKRCC Consultant, and no witness statement was obtained in respect of this individual. In the absence of any confirmation that this individual was in fact present during this conversation, he submitted that this should be redacted as inadmissible as it relates to hearsay from two difference sources.

Paragraph 61 of Witness 2's statement to the NMC

Mr Buxton submitted that the sentence which started, *'*[Owner 1] *asked me to leave the Home immediately* […]*'* is hearsay and potentially prejudicial in your case, as such, it would be unfair in the circumstances to admit. Mr Buxton submitted that by way of completing the picture, there is evidence later on in the statement from the witness describing how it was that certain documents were not retrieved, and the explanation was

given, that as a result of what was said to her by Owner 1, she left the premises, which Mr Buxton does not dispute. Mr Buxton submitted that the sentence should be redacted and disregarded by the panel.

Paragraph 66 of Witness 2's statement to the NMC

Mr Buxton submitted that the line which begins with, *'Georgiana went on a long holiday*[…]' through to the end of the paragraph is irrelevant and has no bearing on the issues.

Paragraph 8 of Witness 3's statement to the NMC

Mr Buxton submitted that in respect of Witness 3's statement to the NMC dated 17 August 2021 in which she exhibited a copy of the Care Quality Commission ("CQC") report, the charges in this case do not relate to any events before October 2020. He submitted that this is simply background which is of no assistance to the panel and if impairment was an issue, then stage two would be the point at which that evidence should be received. He invited the panel to ignore the report at this point of the proceedings.

Paragraph 21 of Witness 3's statement to the NMC

Mr Buxton invited the panel to hear his submissions in respect of this section in private session under Rule 19, given that it relates to a police investigation into Owner 1. He submitted that in such circumstances, the panel may find that it would be best that the information is not made in public.

Mr Buxton submitted that the references to the police investigation of Owner 1 is not relevant to the issue at hand. As such, it is unfair to feature in this case in determining matters against you. He informed the panel that there was never any question of police involvement or law enforcement for you.

Paragraph 22 of Witness 3's statement to the NMC

Mr Buxton submitted that this sentence was prejudicial to your case, and it would be unfair to admit this. As such, he invited the panel to redact the first sentence of paragraph 22 which starts with, '[Owner 1] *kept saying he was a good man…'*.

Paragraph 37 of Witness 4's statement to the NMC

Mr Buxton submitted that in respect of Witness 4's statement to the NMC dated 28 January 2022, paragraph 37 talks about the history of Resident E and is hearsay. Mr Buxton invited the panel to redact sentences two and three of this paragraph.

Provider investigation procedure meeting minutes (Page 41 of Exhibit 2)

Mr Buxton next referred the panel to exhibit '[Witness 1's initials]/5' and identified a section of the minutes of the meeting held with the local authority regarding the observations from the CQC. Mr Buxton submitted that paragraphs 5.14 - 5.20 and 5.22 - 5.23 are not relevant to the panel's consideration of the case because this does not relate to the charges in this case.

Provider investigation procedure meeting minutes (Page 50 of Exhibit 2)

Mr Buxton submitted that the communication and duty of candour (paragraphs 9.1-9.17) of exhibit '[Witness 1's initials]/5' relates to the Nominated Individual (Owner 1) and as such, it is not relevant to your case and should be redacted.

Copy of Witness 4's findings (page 366 of Exhibit 2, exhibit '[Witness 4's initials]/1')

Mr Buxton submitted that it is apparent from the charges that Resident L was not featured. As such, the paragraph headed *'Resident L'* should be redacted in its entirety on the basis that it lacks relevance.

Mr Dowling-Hussey's response on behalf of the Nursing and Midwifery ("NMC")

The panel also had regard to Mr Dowling-Hussey's response to Mr Buxton's application. He submitted that the overarching requirement is the evidence is relevant and fair. He referred the panel to the relevant rule.

Paragraph 16c of Witness 1's statement to the NMC

Mr Dowling-Hussey submitted that there is unfairness in redacting this sentence. It is relevant to Charge 3(iii) and therefore should remain before the panel.

Paragraph 33 of Witness 1's statement to the NMC

Mr Dowling-Hussey invited the panel to look at the totality of the evidence from Resident G. He submitted that this material is relevant to Charge 1(iv) and therefore should remain in the panel's documentation.

Paragraph 44 and 47 of Witness 1's statement to the NMC

Mr Dowling-Hussey told the panel that he intended to provide broadly the same argument for paragraphs 44 and 47. He submitted that the evidence of Witness 1 is relevant to the condition in which Resident E was found. It is not sole and decisive evidence but is evidence that can be of assistance in respect of Charge 4(iv).

Mr Dowling-Hussey submitted that none of the parts of Witness 1's evidence should be redacted. There is nothing to suggest that there was any unreliability in that evidence, and it is possible in the totality of the hearing for that evidence to be tested. Mr Dowling-Hussey submitted that, having regard to the seriousness of the charges and the public interest, the panel should refuse the application in respect of Witness 1's evidence.

Paragraph 19 of Witness 2's statement to the NMC

Mr Dowling-Hussey submitted that this is relevant and necessary, as it speaks to the issue of the lack of training.

Paragraph 38 and 61 of Witness 2's statement to the NMC

Mr Dowling-Hussey submitted that these sections should not be redacted on the basis that they are not prejudicial. It gives some context to the overall evidence from Witness 2.

Paragraph 8 of Witness 3's statement to the NMC

Mr Dowling-Hussey submitted that it is the NMC's position that this paragraph is relevant in summarising the concerns alleged to have occurred at St Augustine's Court Care Home ("the Home").

Paragraph 21 and 22 of Witness 3's statement to the NMC

Mr Dowling-Hussey submitted that there is no agreement by the NMC that these two sections lack relevance or are prejudicial. He submitted that this is relevant and necessary and therefore invited the panel to allow the evidence to remain before the panel.

Paragraph 37 of Witness 4's statement to the NMC

Mr Dowling-Hussey submitted that the evidence provided by Witness 4 is relevant and necessary. He submitted that it is not accepted that there is any unfairness or prejudice to you in relation to the overall case. He therefore invited the panel to refuse Mr Buxton's application in relation to paragraph 37.

Provider investigation procedure meeting minutes (Page 41 and 50 of Exhibit 2)

Mr Dowling-Hussey submitted that paragraphs 5.14-5.20, 5.22-5.23, and 9.1-9.17 of exhibit '[Witness 1's initials]/5' are relevant to the charges and invited the panel to retain this information.

Copy of Witness 4's findings in respect of Resident L (page 366 of Exhibit 2, Exhibit '[Witness 4's initials]/1')

Mr Dowling-Hussey informed the panel that he has not received specific instructions in respect of this, however, he does concede that Resident L is not named in the charges.

Panel decision and reasons

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is *'fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor to the cases of *Thorneycroft v Nursing Midwifery Council* [2014] EWHC 1565 (Admin) and *Ogbonna v NMC* [2010] EWCA (Civ) 1216.

Paragraph 16c of Witness 1's statement to the NMC

The panel decided to redact the four lines of Witness 1's statement which starts with, *'A staff member* […] *that two staff were needed to support Resident N'.* The panel acknowledged that it does not have a statement from the two mentioned colleagues or have any other means to test the reliability of the evidence. The NMC were not able to provide a good reason for these two witnesses not being made available. It noted that there is other evidence that speaks to the charge relating to the dependency tool that it can consider.

Paragraph 33 of Witness 1's statement to the NMC

The panel carefully considered the submissions of Mr Buxton and Mr Dowling-Hussey. It determined that this section is relevant and speaks to charges relating to Resident G. It noted that the evidence is from Witness 1, who has had a conversation with Resident G and was therefore recalling this conversation. The panel considered that Resident G is a vulnerable witness by virtue of his condition and as such, there may be good and cogent reason as to why he has not attended this hearing. The panel noted that it is important that voices of vulnerable witnesses are heard. It has therefore refused to redact paragraph 33. It will decide how much, if any, weight to attach to it in due course.

Paragraph 44 and 47 of Witness 1's statement to the NMC

The panel noted that paragraph 44 and 47 is relevant to Charge 4(iv). The panel considered that in the absence of good and cogent reason for the two named colleagues not being available to explore this evidence further, the panel accepted the application to redact the last five lines of Paragraph 44 and paragraph 47.

Paragraph 19 of Witness 2's statement to the NMC

The panel decided to retain the sentence which states, *'I have asked* [BKRCC Consultant 2] *for a second opinion as to whether the pupils were different sizes and she confirmed',* as Witness 2 is recalling an incident which she was directly involved in and had witnessed. However, the panel found that the comments *'I then asked* [….] *that appeared to be the issue'* not to be relevant and it would not be fair for this to remain before the panel.

Paragraph 38 of Witness 2's statement to the NMC

The panel considered the sentence, *'*[BKRCC Consultant 1] *mentioned to the GP our proposed plan* […] *doctor afterwards*', to be hearsay and not relevant to the charges alleged in this case. It therefore accepted the redaction.

Paragraph 61 of Witness 2's statement to the NMC

The panel decided to redact the sentence which starts with, *'*[Owner 1] *asked me to* […] *towards me'*. The panel was of the view that this was not relevant to the Charge and therefore should be redacted.

Paragraph 66 of Witness 2's statement to the NMC

The panel was of the view that the following sentence, *'Giorgiana went on* […] *in her absence'* is hearsay and adds nothing of substance relating to the charges. It therefore considered this should be redacted.

The sentence which states, *'I felt Giorgiana [PRIVATE] and was disinterested'*, was relevant. The panel took the view that it is fair to remain before the panel and that this could be challenged and tested in evidence.

The remaining sentences of paragraph 66 should not be redacted, as the panel considered these to be relevant to the concerns regarding your leadership. This evidence can be tested in cross examination of other witnesses.

Paragraph 8 of Witness 3's statement to the NMC

The panel noted that paragraph 8 relates to a CQC report from September 2020. The panel acknowledged that the incidents alleged took place after this in October 2020, however, it took the view that this report is important in that it provides a recent context of the environment of the Home whilst you were the Registered Home Manager.

Paragraph 21 and 22 of Witness 3's statement to the NMC

The panel heard and accepted the advice of the legal assessor regarding Mr Buxton's Rule 19 application made during the course of his submissions on redaction. The panel noted that it would be appropriate to go into private session when references were made to the police investigation of Owner 1. The panel has no information before it which

suggests that the third-party investigation has concluded and therefore it would be inappropriate to hear such matters in open session.

In considering the redactions to paragraph 21 (*'The Police were investigating* […] *at the Home or resident's relatives*') and paragraph 22 ('[Owner 1] *kept saying he was a good man* […] *the other staff members'*), the panel decided to allow the redaction as it considered it prejudicial and somewhat ambiguous.

Paragraph 37 of Witness 4's statement to the NMC

The panel decided that the sentence which states, *'*[Owner 1] *stated that Resident E* […] *next month'* was not relevant. The NMC were not able to provide a good and cogent reason for Owner 1 not being available for this evidence to be tested. However, the following sentence, '[Owner 1] *also stated that Resident had not been tolerating the catheter well'* is relevant. The panel took the view that this was not the sole and decisive evidence and could give it the appropriate weight at the relevant stage.

Provider investigation procedure meeting minutes (Page 41 and 50 of Exhibit 2, exhibit '[Witness 1's initials]/5')

The panel considered paragraphs 5.14-5.20, 5.22-5.23, and 9.1-9.17 and noted that they do not relate to the charges in this case. It therefore accepted that these paragraphs should be redacted.

Copy of Witness 4's findings (page 366 of Exhibit 2, exhibit '[Witness 4's initials]/1')

The panel noted that Resident L was not featured in any of the charges and therefore decided that this paragraph is not relevant and should therefore be redacted.

Typographical error in the numbering of Charge 8

Prior to the reading out of the charges, the panel noted that there was a numbering error in Charge 8.

Mr Dowling-Hussey was given time to contact the NMC to seek instructions, however he received no response. He submitted that whilst there is a strong likelihood that this was a typographical error, he was unable to definitively confirm without speaking to those who instructs him at the NMC. However, he informed the panel that it may be a sensible course of action to proceed on the basis that there was a typographical error on the numbering of the subsections for Charge 8.

Mr Buxton was invited to comment, and he informed the panel that he believes that this was the correct course of action.

The panel heard from the legal assessor, who confirmed that it would be appropriate to take this course of action.

The panel therefore decided to proceed on the basis that the numbering on charge 8 contained a typographical error.

The new amendment would read as follows:

'8. Failed to provide adequate care of residents' hygiene and/or well being in that:

(i) On the 15th October 2020, resident H was left in urine-soiled clothes and an uncleaned room.

(ii) On or about the 15th October 2020, Resident H was found to be wearing clothing belonging to numerous other residents.

~~(iv)~~ **(iii)** Left Resident E in a urine soaked room with a malodorous, dirty penis with accumulated skin cells whilst dressed in dirty pyjamas and only dirty linen for his bed

~~(v)~~ **(iv)** Permitted residents to not wear socks or shoes.’

Application to adjourn on Day 6 (30 September 2024)

Mr Cassells on behalf of the Nursing and Midwifery Council ("NMC"), submitted that there is a sudden personal issue has arisen in respect of the Case Presenter, Mr Dowling-Hussey. He invited the panel to adjourn the proceedings under Rule 32 for the following dates, 30 September 2024-4 October 2024 and 9 October 2024-11 October 2024. Mr Cassells submitted that the NMC has no Case Presenter and therefore cannot proceed at this time. He informed the panel that it would not be possible to instruct a new Case Presenter given the stage that this hearing has reached, and it may be the case that there is little that can be done other than to adjourn.

Mr Buxton informed the panel that he was informed of the situation during the weekend and acknowledges that the NMC is in a difficult position given that the case has already commenced. He submitted that the panel has heard from two lengthy witnesses, and this case is not straightforward or a short matter. He asked the panel to consider the practical points and consider further dates to relist and conclude this matter.

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

The panel asked Mr Cassells if he was able to indicate if there is an interim order in place.

Mr Cassells submitted that this issue is one that has been dealt with by the NMC and is not one that need trouble the panel.

The panel noted that this was an unfortunate and unavoidable situation and there is no other option than to adjourn in the interests of fairness to both parties. It took into account the potential inconvenience caused, and it will consider its availability to relist the scheduled dates as soon as possible. The hearing will resume on 17 October 2024 and will sit the 18 October 2024, 24 October 2024, 25 October 2024, 31 October 2024 as originally scheduled and for a further 12 days to be listed as soon as possible.

Details of charges (as amended on 24 September 2024)

That you being a registered nurse, and the Registered Manager of St Augustine's Court Care Home [the "Home"] between September 2020 and December 2020

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:
   (i) On the 14th October 2020, Resident A was left on a mattress lowered near to the floor without assistive technology or a crash mat shouting and in distress for an overall period of 40 or so minutes. **FOUND PROVED**
   (ii) Omitting to undertake risk assessments for either Resident G and/or C when they sought to have their rooms locked at night. **FOUND NOT PROVED**
   (iii) Permitted the practice of locking residents in their rooms on the grounds of preventing them going into others' room. **FOUND NOT PROVED**
   (iv) In or about October 2020, omitted to investigate the cause of bruising on Resident G and/or to refer the same to the Local Authority Safeguarding Team. **FOUND PROVED**
   (v) In or about October 2020, omitted to investigate bruising on resident H's arm potentially caused by restraint and/or poor handling **FOUND PROVED**
   (vi) Did not reverse and/or address the practice in the Home of using restraint. **FOUND NOT PROVED**
   (vii) Did not promote a culture of sharing concerns between staff and management. **FOUND NOT PROVED**
   (viii) Permitted the practice of staff pulling Resident D's fingers apart and/or failed to monitor and/or investigate this abuse. **FOUND NOT PROVED**

(ix) Permitted the practice of drag lifting residents. **FOUND NOT PROVED**

(x) Omitted to ensure that it was safe to accept Resident B, who had Korsakoff syndrome, into the home by way of a full risk assessment. **FOUND PROVED**

2. Failed to provide adequate management and/or supervision of the Home in that:

(i) On the 1st November 2020, upon being informed at home that Staff Member 2 had attempted to strangle Staff member 5 in the course of the night shift

(a) Failed to attend the home to ensure the safety of staff and residents. **FOUND PROVED BY WAY OF YOUR ADMISSION**

(b) Inappropriately allowed both staff members to stay on duty with only a caution to stay apart. **FOUND PROVED BY WAY OF YOUR ADMISSION**

(c) Failed to attend, suspend Staff member 2 and take over the shift yourself. **FOUND PROVED BY WAY OF YOUR ADMISSION**

(d) Failed to investigate the incident properly. **FOUND NOT PROVED**

(ii) Upon notification on the 7th December 2020 by a Staff Member that Resident D, a vulnerable person, had become challenging in a taxi during her transfer to another home, you

(a) Asked or instructed that Staff Member to abandon Resident D in the taxi. **FOUND NOT PROVED**

3. Failed to provide adequate staffing levels generally and in particular in that:

(i) No staff member was designated to observe the CCTV live footage of residents in the home. **FOUND NOT PROVED**

(ii) The system of viewing the CCTV footage did not allow for staff members to reach a resident in need in a more remote place. **FOUND NOT PROVED**

(iii) The dependency tool used to calculate required staffing levels was of a poor quality and insufficient to calculate suitable staff levels. **FOUND PROVED**

(iv) On the 9th November 2020 there was a failure to employ a replacement nurse for one who had resigned **FOUND NOT PROVED**

(v) You omitted to respond to staff concerns about staffing levels. **FOUND NOT PROVED**

(vi) You omitted to engage in addressing staffing levels and/or reporting concerns to the Home's owner **FOUND PROVED**

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:

(i) In relation to Resident H who suffered a seizure on the 2nd November 2020, omitted to intervene and/or provide care. **FOUND NOT PROVED**

(ii) Omitted to provide paramedics with H's medical history **FOUND NOT PROVED**

(iii) On the 25 October and 2nd November 2020, omitted to refer H for a GP review. **FOUND NOT PROVED**

(iv) In relation to Resident E on the 14th and 15th October 2020

(a) Failed to respond to his calls of distress, pain and for an ambulance and **FOUND PROVED**

(b) Failed to consider the cause of his pain and the remedy for it. **FOUND PROVED**

(v) Omitted to obtain formal medical or pharmaceutical authorisation for the use of crushed medication in the covert administration for residents C and J. **FOUND NOT PROVED**

(vi) On the 5th November 2020, in the face of Resident E expressing suicidal intent, you ignored advice from BKR Consultant 1 to refer him to a doctor and claimed his behaviour was “normal” or words to that effect. **FOUND NOT PROVED**

(vii) On or after the 5th November 2020, removed an entry in the nurse’s diary to the effect that Resident E needed a medical referral to claim instead that the same was unnecessary. **FOUND PROVED BY WAY OF YOUR ADMISSION**

(viii) Omitted to monitor and/or audit the ordering and signing for medication at the Home. **FOUND NOT PROVED**

(ix) On the 9th November 2020, when Resident O was being transferred to another home, failed to ensure that her medication accompanied her. **FOUND NOT PROVED**

(x) In or about November 2020 omitted to prevent poor medication practices, namely

(a) Unattended and/or unlocked medication trolleys **FOUND PROVED**

(b) Unattended and/or open medication racks. **FOUND PROVED**

(c) MAR charts lacking 2 signatures when you were tasked with charting. **FOUND PROVED**

(d) Pre-potting along with previous crushed medication. **FOUND NOT PROVED**

(e) Putting tissue paper in medication pots. **FOUND NOT PROVED**

(f) Unhygienic storage of a kidney dish with tweezers and packs. **FOUND PROVED**

(g) MAR charts with medication out of stock **FOUND NOT PROVED**

(h) Multiple pots being dispensed at the same time **FOUND NOT PROVED**

(i) Dispensing medication yourself while another administered it and vice versa **FOUND PROVED**

(j) Lack of ID sheet to identify resident to whom administration intended. **FOUND NOT PROVED**

(k) Trolleys left with both doors open **FOUND PROVED**

(l) Resident J had medication crossed off without dates. **FOUND PROVED**

(m) In Resident B's case, you omitted to action expiry of GKN spray timeously **FOUND NOT PROVED**

(n) In Resident [M]'s case, dates were missing for administration of drugs and when last given. **FOUND NOT PROVED**

(o) You omitted discussion with the doctor in relation to the continuance of medication in Resident O's notes. **FOUND NOT PROVED**

(p) Body maps lacked dates, follow up and progression of wounds. **FOUND PROVED**

(q) There were discrepancies between the nursing and medical notes. **FOUND NOT PROVED**

5. Failed to provide adequate care plans and/or clinical notes in that you:

(i) On the 14th and/or 15th October 2020, after Resident E complained of pain, omitted to create an appropriate catheter care plan and/or failed generally thereafter prior to the 27 October 2020 to adequately update the catheter care plan.

(a) You did not mention the strap for the catheter needed to be attached to the thigh **FOUND PROVED**

(b) You provided different time scales for the changing of the catheter. **FOUND NOT PROVED**

(c) You did not provide any guidance as to blockages and/or infection. **FOUND PROVED**

(ii) In or about September 2020, omitted to provide Resident A with an appropriate care plan and failed adequately thereafter prior to the 27 October to review and update the care plan in that

(a) The low bed was not mentioned in the care plan **FOUND PROVED**

(b) Dementia, confusion, unsteady mobility and the low bed were not identified as risks. **FOUND PROVED BY WAY OF YOUR ADMISSION**

(c) There was no risk assessment nor one for Resident A's understanding of the risk. **PARTIALLY PROVED**

(d) One hourly checks directed by the plan could not meet the risk. **FOUND PROVED**

(iii) Omitted to ensure that Resident B's care plans included his problematic behaviours, the triggers for those problems and the action needed. **FOUND PROVED**

6. Failed to provide adequate training of staff in that you:

(i) Omitted to provide up to date documentation on Resident H's medical seizure care to allow staff to assess him appropriately. **FOUND NOT PROVED**

(ii) Omitted to train staff in the safe care, maintenance and securing of catheters. **FOUND PROVED**

(iii) In November 2020, omitted to train and/or guide staff how to wear PPE during the covid pandemic. **FOUND NOT PROVED**

(iv) Omitted to provide adequate training in the management of challenging behaviour. **FOUND NOT PROVED**

7. Failed to provide an adequate safe and risk-free environment in that you:
    (i) Left the kitchen hatch open (with access to knives) when one of the Residents [E] was expressing suicidal intent **FOUND NOT PROVED**
    (ii) Individual needs were not described in Personal Emergency Evacuation plans. **FOUND PROVED**
    (iii) Permitted the home to contain hazards
        (a) Accessible razors **FOUND NOT PROVED**
        (b) Fabric of chair breached to create infection control risk **FOUND PROVED**
        (c) Blocked exterior fire exit **FOUND PROVED**
        (d) Broken window **FOUND PROVED**
        (e) Combustible materials along walkway **FOUND NOT PROVED**
        (f) Expired food **FOUND NOT PROVED**
        (g) Padlocked gate preventing evacuation **FOUND PROVED**
        (h) Password stuck to computer **FOUND PROVED**
        (i) Cubicle in which medication trolley kept unlocked. **FOUND PROVED**
        (j) Suicide-risk Resident S not having a call bell **FOUND NOT PROVED**
        (k) Broken toilet and roll holder. **FOUND PROVED**
        (l) Apron cord out as ligature risk **FOUND NOT PROVED**
        (m) Food open without note when opened. **FOUND NOT PROVED**

8. Failed to provide adequate care of residents' hygiene and/or well being in that:

(i) On the 15th October 2020, resident H was left in urine-soiled clothes and an uncleaned room. **FOUND NOT PROVED**

(ii) On or about the 15th October 2020, Resident H was found to be wearing clothing belonging to numerous other residents. **FOUND NOT PROVED**

(iii) Left Resident E in a urine soaked room with a malodorous, dirty penis with accumulated skin cells whilst dressed in dirty pyjamas and only dirty linen for his bed **FOUND PROVED**

(iv) Permitted residents to not wear socks or shoes. **FOUND NOT PROVED**

9. On the 25th October 2020, when Resident H fitted whilst you were on duty and he was in your care, you failed to seek a medical review for him. **FOUND NOT PROVED**

10. On the 2nd November 2020 failed to provide any assistance or support to your staff when Resident H fitted again. **FOUND NOT PROVED**

11. Subsequently when asked by BKR Consultant 1 whether you had been on duty when Resident H fitted on an occasion prior to the 2nd November 2020, you inaccurately stated you had not. **FOUND NOT PROVED**

12. Your answer at 11 was dishonest in that

(a) You knew you had been on duty at a previous fit on the 25th October 2020 **FOUND NOT PROVED**

(b) You had recorded that fit in the notes. **FOUND NOT PROVED**

13. Failed to update your own clinical knowledge beyond mandatory in-service training by reference to additional reading and attendance at forums. **FOUND NOT PROVED**

14. In all or any of the above, failed to provide sufficient and/or adequate leadership for the Home. **FOUND PROVED**

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

Admissions

At the outset of the hearing, the panel heard from Mr Buxton, who informed the panel that you made full admissions to Charges 2(i)(a), 2(i)(b), 2i(c), 4(vii) and 5(ii)(b).

The panel therefore finds Charges 2(i)(a), 2(i)(b), 2i(c), 4(vii) and 5(ii)(b) proved by way of your admissions.

Background

On 20 November 2020, you were referred to the NMC by the Care Quality Commission ("CQC") regarding concerns whilst you were a Home Manager at St Augustine's Court Care Home ("the Home").

The CQC carried out inspections at the Home on 14, 15 and 27 October 2020 and identified serious concerns. As a result of the concerns, NHS Nottingham and Nottinghamshire Clinical Commissioning Group ("CCG") in partnership with Nottingham City Council commissioned BKR Care Consultants ("BKRCC") to support the day-to-day management of the service and provide clinical oversight of service users.

BKRCC raised a number of concerns about your management of the Home. This included your failure to recognise the issues facing the Home and the overall safety of its residents as outlined in the charges.

The CQC suspended you as a Registered Manager.

Decision and reasons on facts

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

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

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

- Witness 1: CQC Inspector for the East Midlands Hub at the time of the alleged events.
- Witness 2: Care and Clinical Director at BKRCC at the time of the alleged events.
- Witness 3: Inspector Manager at the CQC at the time of the alleged events.
- Witness 4: Safeguarding Adults Specialist Practitioner at Nottingham and Nottinghamshire Clinical Commissioning Groups at the time of the alleged events.
- Witness 5: Registered Nurse employed by the Home at the time of the alleged events.

- Witness 6: CQC Inspection Manager at the time of the alleged events.
- Witness 7: Administrator at the Home at the time of the alleged events.

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

- Dr 1: Attending General Practitioner ("GP") for the Home at the time of the alleged events.
- Witness 8: Registered Nurse at the time of the alleged events and Owner 1's spouse.

The panel also heard evidence from you under affirmation.

During the course of your live oral evidence, Mr Buxton made a request to hear parts of the hearing in private to clarify that your knowledge of residents matched those listed in the schedule of anonymity.

Mr Dowling-Hussey informed the panel that he had no objection for the hearing to go into private when such matters are discussed.

The panel agreed for the hearing to go into private session to allow you to confirm your understanding of the Residents referred therein your oral evidence.

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

The panel heard live evidence from the CQC inspectors (Witnesses 1, 3, and 6), who attested that you were the Registered Home Manager at the time to which the charges relate. The panel noted that at the time of your appointment as Home Manager, you raised concerns that you did not possess the relevant experience to be promoted to this role by Owner 1, but you were assured by Owner 1 that he was there to support you. The panel heard various accounts from witnesses that Owner 1 was a domineering character who had a very active role within the day-to-day running of the Home. The panel found that when you accepted the role, you lacked a clear understanding of the difference between the role of the owner and the Registered Manager. You told the panel that you were unaware that you had to have an interview with the CQC prior to your appointment as Registered Home Manager (and only discovered this from another individual within your network). The panel heard evidence from you that you were under the impression that the day-to-day responsibility for the Home rested with Owner 1 and you therefore felt constrained in making managerial decisions.

The panel noted that it is undisputed that, as the Registered Care Home Manager for St Augustine's, you followed the process in registering with CQC as the Home Manager. The panel questioned the robustness of the CQC registration process in light of the evidence it heard during the course of these proceedings. The panel noted that the inspection on 14 October 2020 was conducted 36 months after your appointment.

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

Charge 1(i)

That you being a registered nurse, and the Registered Manager of St Augustine's Court Care Home [the "Home"] between September 2020 and December 2020

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:

(i) On the 14th October 2020, Resident A was left on a mattress lowered near to the floor without assistive technology or a crash mat shouting and in distress for an overall period of 40 or so minutes.

Charge 1(i) is found proved.

The panel considered the stem of the charge, in that, in order to find this charge proved, you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse. The panel heard evidence from Witness 1 and Witness 6 that you were the Registered Manager of the Home, and whilst the panel has not seen a job description, it was satisfied that you bore a legal responsibility for the Home and its residents.

The panel took into account Witness 1's evidence in respect of Resident A. In Witness 1's witness statement to the NMC dated 31 August 2021, they stated:

'22. I observed Resident sat in her bed. Resident A had a bed that could be lowered to the floor and her mattress had been lowered and was nearly touching the floor. I observed that Resident A [sic] *bottom was sat on her mattress and her legs were straight in front of her on the laminate flooring.* […] *Distress in Resident A* ' [sic] *voice escalated at 21:07 until 21:12*

23. […] *No other staff came onto the corridor to hear Resident A '* [sic] *shouts. No one entered Resident A '*[sic] *room to identify that she was sat in low bed and may want to get up or need support to prevent a fall. I had observed there was no assistive technology in the room (e.g. motion sensors) to alert staff that she was up.*

24. At 21.45, I checked in the room again and saw Resident still sat in bed with her legs out of the bed. Resident remained shouting out (but more

quietly than before) and still appeared in distress. Resident' [sic] *language was not understandable. Between 21:13 and 21:45, I was in and out of other people's bedrooms but had still not seen staff near Resident ' room during this time. This was a period of nearly 40 minutes where Resident had been requiring support and no staff had been deployed nearby to respond. '*

The above incident was supported by Witness 2's oral evidence of what they witnessed on the day of the unannounced visit.

The panel noted that the above incident was undisputed and therefore went onto consider whether there had been a failure on your part to safeguard Resident A from the risk of harm and/or abuse. You told the panel during your oral evidence that the shouting was a typical presentation from Resident A and the dementia outreach team was aware of this. In respect of the low bed, you stated that this was required, as Resident A was *"frail"* and frequently found at the edge of the bed and hence the mattress was lowered by a staff member. They told you they did this to avoid potential injury. You accepted that at the time that the CQC visited, Resident A was on a low mattress, and that when you were informed by the CQC of their concerns in respect of assistive technology, you accepted that there was a need to put a crash mat and sensor to safeguard Resident A and you subsequently promptly remedied this.

The panel considered that as the Home Manager, it was your role to ensure that care plans are clear and sufficiently detailed for nurses or carers to follow. It noted that after the matter was brought to your attention, you recognised that there was an issue and you remedied this by putting a crash mat and sensor in place. The panel determined in light of your evidence, that although you had considered the risk of Patient A falling out of bed, your actions fell short of adequately safeguarding Resident A from a risk of harm in that, prior to your remedial actions, Resident A was

left on a mattress lowered near to the floor without assistive technology and therefore would be unable to get themselves up or alert staff.

Accordingly, the panel found Charge 1(i) proved.

Charge 1(ii)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:
   (ii) Omitting to undertake risk assessments for either Resident G and/or C when they sought to have their rooms locked at night.

Charge 1(ii) is found NOT proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider the matters in respect of Resident G and C.

The panel took into account Witness 1's statement to the NMC dated 31 August 2021 in relation to Resident G which stated:

> *'31. Resident G informed me that she requested to be locked in her room at night as she did not feel safe from other residents. I observed staff lock Resident G in her room. Resident G was very coherent and I believe she had capacity at the time to make this request. I discussed this with* [you] *and* [Owner 1] *on the night of 14 October 2020. Both were aware of this practice of locking Resident G in her room. There was no risk assessment into this practice despite all bedrooms had a keysafe to put in a bedroom door key. It is important that this is risk assessed as locking Resident G in her room would put her at risk in an emergency.'*

Witness 1 further stated in her oral evidence:

> *"Throughout the care home, a lot of bedrooms were locked with key safes, so they were either locked or they had a key safe available to lock it if they wanted. One of the residents that I came across was Resident G* […] *She was cognitively very well and able to discuss that. She liked the door being locked because she was worried about people coming into her room. So there is, there is obviously people who have a choice as to how they want to be cared for. Some people in the care home may choose to be locked in their room, but I couldn't see that within care planning or risk assessment documents because if you choose to lock someone in there would usually be decisions. For example, how to evacuate them safely, how to check on them when their room's locked, that sort of thing. So there would be decision making processes around that and I couldn't see that for this person."*

In looking at the evidence for Resident C, the panel had regard to Witness 3's witness statement to the NMC dated 17 August 2021 which stated:

> '[…] *Resident C locking her bedroom door at night because other residents would wander into her room but there was nothing done by the Home which instilled fear in Resident C that she had to lock her bedroom door.'*

You told the panel in your oral evidence that due to the nature of the residents (who had complex needs) in the Home, some would enter other residents' rooms *"taking belongings* […] *urinating"* and as such, a number of complaints were raised regarding this matter. You gave evidence that the owner suggested that having a key safe outside each bedroom would be a good idea, so that rooms could be locked when a resident was out of the room. You also told the panel that relatives had been informed and agreed with this course of action. You further explained that once a resident was ready to leave their room for the day, the carer would lock the door for them and put the key back in the box.

The panel found that whilst there was no evidence of a risk assessment before it in respect of Resident G and C, it understood that both residents had mental capacity. In this case, both residents (albeit Resident G was immobile), had expressed that they wanted their rooms locked. In considering whether this posed a risk of harm to either patient, the panel noted that the key safes (to which witnesses and you have attested to be positioned directly outside of the residents' rooms) were accessible should there be a need to gain access into the respective resident's room. Further, for Resident C, who was mobile, they were able to lock the room as and when they wished and therefore, the panel was not satisfied that you failed to provide adequate safeguarding of residents from the risk of harm.

Accordingly, the panel found Charge 1(ii) not proved.

Charge 1(iii)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:
   (iii) Permitted the practice of locking residents in their rooms on the grounds of preventing them going into others' room.

Charge 1(iii) is found NOT proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider whether permitting the practice of locking residents' in their rooms on the grounds of preventing them from going into others' room was a failure to provide adequate safeguarding of residents from the risk of harm and/or abuse.

The panel took into account your explanation given during your oral evidence in that the Home received complaints about residents entering each other's rooms. As a

result, it was agreed that residents' rooms would be locked when residents were not inside. The panel heard evidence that whilst a locked room would need a key to access it from outside the door, the door could be opened without a key from the inside, meaning that any residents with mobility and capacity could open the door from inside themselves without a key. The panel found that, in effect, there was no difference between the door being locked or simply closed for anyone inside the room.

Your account was supported by Witness 5's oral evidence in which she told the panel that the purpose of the key safe was to enable the doors to be locked during the day when residents were in the communal areas, as some residents had a tendency to wander into other residents' rooms and urinate or take belongings and the locking of the doors prevented this.

The panel found Witness 5 and your evidence to be consistent. As such, it was satisfied there was no practice of locking of residents in their rooms, and, in any event, the doors could be opened from the inside. Consequently, there was no failure to provide adequate safeguarding of residents from the risk of harm and/or abuse.

Accordingly, the panel found Charge 1(iii) not proved.

Charge 1(iv)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:
   (iv) In or about October 2020, omitted to investigate the cause of bruising on Resident G and/or to refer the same to the Local Authority Safeguarding Team.

Charge 1(iv) is found proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider whether in or about October 2020, you omitted to investigate the cause of bruising on Resident G, and/or to refer the same to the Local Authority Safeguarding Team.

The panel considered Witness 1's statement to the NMC dated 31 August 2021 which stated:

> *'33. Resident G reported that staff were 'rough' with her. Resident G told me staff 'just push me and pull me around to get it done' and that 'staff are not gentle here.' Resident G told me that she had reported this to the management team, but that nothing has been done. We reported this concern in our letter of intent and the response was that the bruises were in a previous care setting, and the rough nature of staff was compared to a hospital Nurse. The respondent did not state that this allegation would be referred to the Local Authority Safeguarding team. They did not state that further investigations would occur into why Resident G felt staff were rough compared to previous care settings. I believe there was a lack of action taken to address the bruising concerns raised by Resident G. This poor management response left other residents at risk of bruising occurring again.'*

You told the panel that after Witness 1 brought the matter to you, you spoke to Resident G. You carried out an observation on Resident G and did not find a bruise. You said that during this conversation, Resident G told you about an incident when she was in hospital and the staff were "*rough"* with her and caused a bruise using a hoist. You said that Resident G compared the staff in the Home to the hospital staff and that *"here, she didn't have any bruise".* You further told the panel that when you asked Resident G whether she had concerns about the staff at the Home, Resident

G said, *“no* […] *she mentioned to the inspectors the bruises was caused in the hospital, not in the care home”*.

The panel found that Witness 1 and you were both consistent in evidence in that Resident G had capacity and had stated that the staff in a previous clinical setting were rough with her. You told the panel that the reason there was no further investigation into this matter was because Resident G had been clear that this bruise was caused at a previous care setting and not at the Home. Whilst the panel has not seen any evidence in the form of a photographic evidence from Witness 1 to support the charge that Resident G had a bruise which was sustained whilst she was residing at the Home, the panel determined that you had received clear information from Resident G of maltreatment in a previous care setting and you had a duty to report it. The panel determined that there had been a failure on your part to fully investigate the cause of the bruising and refer the matter to the local authority safeguarding team.

Accordingly, the panel found Charge 1(iv) proved.

Charge 1(v)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:

    (v) In or about October 2020, omitted to investigate bruising on resident H’s arm potentially caused by restraint and/or poor handling

Charge 1(v) is found proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider whether in or about October 2020, you failed

to provide adequate safeguarding of residents from the risk of harm/and or abuse in that you omitted to investigate bruising on Resident H's arm potentially caused by restraint and/or poor handling.

The panel noted Witness 1's evidence to the NMC dated 31 August 2021 which stated:

> *'37. On 15 October 2020, I showed Giorgiana the bruises on Resident 's arm. I explained to Giorgiana that both I, and the visiting CCG Nurse, felt this was evidence of bruising from being held. Giorgiana was seen to ask a staff member about the injury, who told her that Resident H had been scratching himself. Giorgiana therefore responded to me that the injury was because Resident H scratched himself.*
>
> *38. Giorgiana then stated that Resident H had not been grabbed. I continued to explain that both I, and* [a CCG Nurse]*, felt these were restraint type bruises Giorgiana remained insistent that this was due to being scratched and gave no confirmation that she would investigate the unexplained bruising or refer to the safeguarding team to investigate. Due to my extensive concerns, I would expect Giorgiana to have responded more thoroughly to this incident. Particularly as she is a registered person and responsible for the safety of residents at the care home.'*

Witness 1 said during cross examination as to what they expected you to do when the matter was raised. Witness 1 stated:

> *"If another professional is making an allegation of abuse, I'd* [sic] *expected her to have referred to safeguarding that day."*

The panel also had regard to Witness 4's oral evidence and statement to the NMC dated 28 January 2022 which stated:

> *'11. On Resident H's left arm I noticed he had four small bruises to his forearm, they appeared consistent with presentation of fingertip bruising (photographed by the CQC Inspector). This is likely evidence which suggests that Resident H has received sustained pressure from a staff member's hold at some time. Although the bruising appeared old and has faded, the remaining deep red marks suggest that the trauma was intense and would have been a substantial injury when it first occurred.'*

You told the panel that a chart was completed by Senior Carer 1, who informed you that there was an incident in which Resident E grabbed Resident H. You said that you did not see any bruising but you completed an incident form. You further explained that Resident H is known to have unpredictable behaviour, as such, you were not concerned. You further suggested during your oral evidence that the bruises could be caused by Resident H grabbing his own arm which could be exacerbated by the fact that Resident H was on the medication *"Clopidogrel"* which acts as a blood thinner.

The panel determined that you had a duty to investigate the bruises on Resident H's arm and heard no evidence to indicate that you had taken any action and had made an assumption as to the cause. The panel found this to be a failure to investigate the bruises on Resident H's arm to a satisfactory level and therefore you failed to adequately safeguard Resident H from a risk of harm and/or abuse.

Accordingly, the panel found Charge 1(v) proved.

Charge 1(vi)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:

(vi) Did not reverse and/or address the practice in the Home of using restraint.

Charge 1(vi) is found NOT proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider whether, in not reversing and/or addressing the practice in the Home of using restraint, you failed to provide adequate safeguarding of residents from the risk of harm/and or abuse.

Witness 1 stated in her statement to the NMC dated 31 August 2021:

> *'41. I was also concerned about the culture of restraint at the Home. I asked staff whether they ever held people and they confirmed they did. They described this as 'passive restraint'. This is a term that* [Owner 1] *and Georgiana also used. When I asked for this passive restraint to be demonstrated by staff, I placed my hand on a desk and staff members put their hand on top. They showed me that as I tried to move my hand away they pressed down, increasing the force and pressure to prevent me from removing my hand. This practice did not allow a person to remove themselves easily from the situation and is possible to cause injury to the person. I would not consider it to be a 'passive' act. It is not the least restrictive method of providing care and not in line with good dementia care principles.'*

Witness 1 further explained in her oral evidence:

> *"I've never heard of the word 'passive restraint' before or after going to Saint Augustine's care home. It's not something that I would recognise to be a*

national guidance or anything, and their policies were written by themselves. So, I'm not sure how they've used passive restraint- where they got that term from- but I don't think it was particularly clear within the policy. So that's why I spoke to staff about their interpretation of what that meant."

During cross-examination, Witness 1 stated that if a resident became aggressive, she would expect the member of staff dealing with the patient to use other tactics and for "*restraint to be the last resort".*

You told the panel that the Home received a visit from the Dementia Outreach Team and discussed restraint. A staff member demonstrated the use of restraint to a member of the Dementia Outreach Team who said that the method used by the Home was *"fine".*

The panel bore in mind that Witness 1 was not a qualified nurse. The panel also took into account the nature of the residents at the Home. These included residents diagnosed with complex cognitive conditions, some of which may also display challenging behaviours. The panel has not been provided with the Home's policy on restraint but noted that, given the complexity of the Home's residents, accepted there may have been occasions in which restraint would be necessary in order to protect residents from their own or others' behaviour. You demonstrated the practice of restraint to the panel which appeared to be guiding rather than restraining. It also took into account that you had sought advice from the Dementia Outreach Team as to the methodology in dealing with patients. No concerns were raised at the time this was demonstrated.

The panel determined that the level of restraint described in evidence appears reasonable and proportionate to the nature of the Home. As such, the panel found that insufficient evidence was presented to demonstrate a need to reverse or address the use of restraint in the Home.

Accordingly, the panel found Charge 1(vi) not proved.

Charge 1(vii)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:
    (vii) Did not promote a culture of sharing concerns between staff and management.

Charge 1(vii) is found NOT proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider whether you did not promote a culture of sharing concerns between staff and management, and in that, you allegedly failed to provide adequate safeguarding of residents from the risk of harm/and or abuse.

The panel had regard to Witness 1's statement to the NMC dated 31 August 2021, they stated:

> *'53. At a good service, I would expect staff to feel able to raise issues/concerns to the management team. Then for the management team to respond to concerns. Staff feedback showed that this culture was not in place. In addition, when I returned to the Home on 27 October 2020 staff were unaware of what the CQC concerns were. We would expect the management team to have shared our concerns with the staff team, in order to create improvements. I believe that the Home had a closed culture as staff felt their concerns would not be listened too. When CQC concerns were raised in the letter of intent, I observed that the response from the management team was also poor.'*

In Witness 3's statement to the NMC dated 17 August 2021, they stated:

> *'9.* […] *The Home had a closed culture and I based on what I was told it appeared that staff were intimidated by* [Owner 1] *which had a negative impact* [on] *the level of care of the residents.'*

You told the panel in oral evidence:

> *"I always try to have a good relationship with my staff based on being honest and open, to be able to come and raise any concerns* […] *My door was open all the time, so we have an open policy in place and also, we have in the staff room, an anonymous box where the staff could write and put everything inside. We have as well a diary which was kept in the staff room, so they could write their concerns and we've been checking this every week. The team meetings as well."*

In Witness 5's statement to the NMC dated 29 March 2022, they stated:

> *'9. The NMC asked me to comment on the atmosphere of the Home. We have a close team of staff and we are there for each other. However, when* [Owner 1] *became the owner there was a real strain on the staff. The environment began to get increasingly difficult and stressful to work in. We were taking on challenging residents and the workload increased but we did our best to look after them. The staff would try to make the shift pleasant for one another. The Home is a home from home for most of the staff.'*

Witness 5 gave oral evidence that you were *"approachable", "always visible-* […] *wasn't locked away in office"* and *"attended staff meetings".* This was supported by Colleague 1's hearsay statement dated 13 February 2025 which stated:

‘2. As a manager I felt Giorgiana was very approachable and friendly [sic] *I always felt comfortable taking to her and raising any issues.* […] *She used to attend meetings with other professionals and also families if they had any concerns.*

3. We used to have meetings through the week at 11am with Giorgiana to raise any concerns or changes with the residents and this would be acted on. […] *She was a good manager and I could take issues to her, she was very approachable.* […] *she was a great manager to me’*

The panel also heard from Dr 1 that he considered the Home as a *“friendly home”* under your leadership.

The panel considered your evidence, as well as those of Witness 5, Colleague 1 and Dr 1. The panel determined that you were approachable, visible and were present in staff meetings. You had an open door and had a staff room suggestion box to allow colleagues to raise concerns should they wish to do so anonymously. Therefore, the panel was satisfied that you did promote a culture of sharing. However, this sharing culture was impeded because your ability to effect change was diminished due to the constraints you faced by Owner 1.

In terms of the concerns raised by the CQC and sharing these with the staff, there is no evidence before the panel which suggests that you received the letter of intent dated 15 October 2020, as this was sent directly to the owner.

Accordingly, the panel found Charge 1(vii) not proved.

Charge 1(viii)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:

(viii) Permitted the practice of staff pulling Resident D's fingers apart and/or failed to monitor and/or investigate this abuse.

Charge 1(viii) is found NOT proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider whether you permitted the practice of pulling Resident D's fingers apart and/or failed to monitor and/or investigate this abuse, and in that, you failed to provide adequate safeguarding of residents from the risk of harm/and or abuse.

The panel had regard to Witness 4 statement to the NMC dated 28 January 2022 which stated:

'22. The CQC Inspector spoke with Resident D to ask if she was happy living here. As Resident D has communication difficulties in terms of her speech we was [sic] *really struggling to understand her, however she did seem to understand our questions to an extent. Initially Resident D seemed reluctant to talk to us but after showing her our identification badges she appeared more reassured. The CQC Inspector asked Resident D if she was scared of staff. Resident D looked immediately towards the door. Resident D appeared worried to talk to us in case someone walked in the room, it was her body language and facial expressions that indicated how anxious she was about this. Resident D was unable to provide a clear answer and indicated on herself the pulling of fingers apart.'*

You told the panel that Resident D was unpredictable and that this concern was never raised with you at the time. You said that Colleague 2 told you that Resident D was agitated and had her hand inside her handbag. She then sustained the injury

when she caught her hand from the inside of her handbag. You said that Colleague 2 told you what happened and showed you an accident form. You said that Colleague 2 called a doctor to discuss the injury.

The panel found that the NMC's evidence was conjecture and based on gesticulations from Resident D who lacked capacity and the ability to communicate coherently, which may or may not have indicated that such an incident did in fact take place. Resident D was suffering from severe dementia at the time and apart from the evidence of Witness 4, the panel had insufficient evidence before it to find this charge proved.

Accordingly, the panel found Charge 1(viii) not proved.

Charge 1(ix)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:
    (ix) Permitted the practice of drag lifting residents.

Charge 1(ix) is found NOT proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider whether you permitted the practice of drag lifting residents, and in that, failed to provide adequate safeguarding of residents from the risk of harm/and or abuse.

The panel took into account Witness 2's supplementary statement dated 15 July 2024:

'*6. During my first week in the service, I also took the following pictures of what I perceived to be evidence of poor practice. The number sequence was automatically assigned by my work iPhone.*

[…]

6.3. Exhibit [Witness 2's initials]/35 – *IMG-5129. Image of* [Witness 8] *(centre left person), Giorgiana (middle person) and carer (left person) holding a service user up by the arms and underarms to prevent them sitting on a foot stool. I witnessed this incident the service user was ('Resident C') There was no reason to prevent her from sitting on the stool, though it was of a design not permitted in care settings as it did not have adjustable height functions.*

6.4. The act is considered a drag lift, which is a safeguarding issue due to the whole of the service user's weight being put through their shoulder joints, which can cause pain and or dislocation of the joints.'

During your oral evidence, you were shown the photograph taken by Witness 2 and said:

"So apparently there was a footstool and she wanted to sit in that footstool and the [other] *resident, who was in the chair already, was trying to kick* [the resident in the photograph]*. So* [Witness 8] *saw this and she went there to support the resident to move her from there before being kicked by that resident.* […] *in that time, I came in the lounge and I saw them walking with the resident, so I went near the resident. But I was more in one side in the back trying to speak with the resident behind her because they already* [were] *dealing with this resident and I was speaking with the resident behind* [the] *Lady. I didn't touch the resident at all."*

The panel had regard to the photographic evidence exhibited by Witness 2 but found that the photo was unclear. It appears to show three members of staff assisting a resident but the quality of the photograph was so poor that the panel cannot make a clear distinction as to whether the resident (who was barely visible) was being drag lifted. The panel heard from Witness 8 (who also had difficulty in identifying the people contained within the photograph) that there was no practice of drag lifting within the Home. You also denied that you were touching the resident and said that you were actually speaking to the resident who tried to kick the other resident being assisted by Witness 8. Therefore, the panel found that there was insufficient evidence that the practice of drag lifting had taken place nor has the NMC provided evidence to support this.

Accordingly, the panel found Charge 1(ix) not proved.

Charge 1(x)

1. Failed to provide adequate safeguarding of residents from the risk of harm and/or abuse in that:
    (x) Omitted to ensure that it was safe to accept Resident B, who had Korsakoff syndrome, into the home by way of a full risk assessment.

Charge 1(x) is found proved.

The panel, having been satisfied that you, as a Registered Nurse and the Registered Manager, had a duty to provide adequate safeguarding of residents from the risk of harm and/or abuse, went onto consider whether you omitted to ensure that it was safe to accept Resident B, who had Korsakoff syndrome, into the Home by way of a full risk assessment, and as such, failed to provide adequate safeguarding of residents from the risk of harm/and or abuse.

The panel considered Witness 6’s statement to the NMC dated 12 August 2024:

'9. […] *('Resident B' – referred to in the letter as Service User 1) had seriously injured another service user at a previous placement by pushing them down the stairs. I cannot remember if that person had died as a result. Resident B had Korsakoff syndrome. Based on his history, I would have expected to see in his care plan what the problematic behaviours were, what triggered them, and how staff planned to do when those behaviours occurred to ensure that he and people around him were safe. This information was not in Resident B's care plans.'*

The panel also had regard to two care plans created by you for Resident B dated 21 November 2019 and 22 July 2020. The panel noted that these were not risk assessments which were created prior to Resident B's admission into the Home.

The panel noted that it was good practice to ensure that a risk assessment is conducted prior to the admission of any residents. The panel heard evidence from you that, given your perception that the Home was under the control and direction of Owner 1, you considered that pre-admissions were Owner 1's choice and the starting point for you would be to accept all new residents.

The panel considered the care plans dated 21 November 2019 and 22 July 2020. It found that you gathered information for the care plan. However, the panel noted that there was insufficient information regarding the one-to-one care for a complex resident, which included where the additional resources for the resident would have come from. The panel found that this required a more in-depth discussion and assessment as to the risk this resident posed to the staff, other residents and to himself.

Accordingly, the panel found Charge 1(x) proved.

Charge 2(i)(d)

2. Failed to provide adequate management and/or supervision of the Home in that:
   (i) On the 1st November 2020, upon being informed at home that Staff Member 2 had attempted to strangle Staff Member 5 in the course of the night shift
   […]
   (d) Failed to investigate the incident properly.

Charge 2(i)(d) is found NOT proved.

The panel was satisfied that in the course of your role as the Home Manager, you had a duty to provide adequate management and/or supervision of the Home.

In considering this charge, the panel noted that Witness 2 alleged that this incident took place on 1 November 2020. However, the documentary evidence before the panel indicates that the incident occurred on 28 October 2020, prior to Witness 2's arrival in the Home.

The panel considered the local witness statement handwritten by Colleague 3 (Staff Member 5) which appears to date the alleged incident to 28 October 2020 and typed and signed on the same date.

The panel accepted that the incident took place on 28 October 2020 and not on the date as believed by Witness 2.

The panel next considered whether you have failed to investigate the incident properly. The panel noted your position in that you were aware of the incident from the start and that you felt that you had dealt with the matter accordingly.

The panel had sight of the local Investigation Meeting Notes dated 6 November 2020. Amongst those present was a member of BKRCC and yourself. The panel

noted that following the local investigation meeting, Colleague 4 (Staff Member 2) was suspended and subsequently dismissed.

The panel considered whether the local investigation meeting notes provided a sufficient process into the incident. The panel decided that this was sufficient on the basis that an incident had taken place, and the conduct of the individuals involved had been explored through a formal investigatory process. This involved interviews with all staff on duty at the time, local statements and a formal investigatory meeting that included a notetaker. As a result of this, an outcome was reached to suspend Colleague 4 (the aggressor) and subsequently dismiss them. As such, the panel was satisfied that you adequately managed the situation involving these two staff members in respect of how you investigated the incident.

Accordingly, the panel found Charge 2(i)(d) not proved.

Charge 2(ii)(a)

2. Failed to provide adequate management and/or supervision of the Home in that:

(ii) Upon notification on the 7th December 2020 by a Staff Member that Resident D, a vulnerable person, had become challenging in a taxi during her transfer to another home, you

(a) Asked or instructed that Staff Member to abandon Resident D in the taxi.

Charge 2(ii)(a) is found NOT proved.

The panel was satisfied that during your role as the Home Manager, you had a duty to provide adequate management and/or supervision of the Home.

The panel had regard to Witness 2's statement to the NMC dated 24 May 2022 in which it stated:

> *'60. Giorgiana had received a call from a staff member, I believe it was* [Senior Carer 1]*, about who had become challenging in a taxi and Giorgiana asked them to abandon in the taxi.* […]*'*

The panel took your evidence into account which included text messages between you and Senior Carer 1 during the alleged incident:

> '[You]: *I* [sic] *been instructed by the director when you drop* [Resident D] *there* […] *tell you to came* [sic] *back at the care home Giorgiana*
>
> […]
>
> *Give hand over and ensure she is safety* [sic] *and came* [sic] *back The director said you are not covered by insurance Thanks*
>
> [Senior Carer 1]: *Ok I'll* [sic] *will thanks*
>
> *What am* [sic] *supposed to tell them at the care home if they want me to stay*
>
> [You]: *Call* [Witness 8] *and she will inform you*
>
> *Stay if the resident is not settled …ensure is* [sic] *settling, give properly* [sic] *hand over'*

The panel found that Witness 2's evidence and yours were contradictory. It noted that Witness 2 was not part of the conversation regarding the transfer of Resident D, and as such, may have misunderstood the conversation between you and Senior Carer 1. The

panel preferred your evidence which was supported by the text messages exchanged between you and Senior Carer 1. It also heard evidence from Dr 1 who attested that you had a good relationship with the residents in the Home. The panel determined that it was therefore highly unlikely that you would instruct that a resident be abandoned in the taxi taking them to a new home.

Accordingly, the panel found Charge 2(ii)(a) not proved.

Charges 3(i) and 3(ii)

3. Failed to provide adequate staffing levels generally and in particular in that:
    (i) No staff member was designated to observe the CCTV live footage of residents in the home.
    (ii) The system of viewing the CCTV footage did not allow for staff members to reach a resident in need in a more remote place.

Charges 3(i) and 3(ii) are found NOT proved.

The panel was satisfied that, as the Registered Home Manager, staffing levels fell within your remit. The panel then moved onto consider whether you failed to provide adequate staffing levels generally in respect of Charges 3(i) and 3(ii).

In considering Charge 3(i), the panel took into account Witness 1's statement to the NMC dated 31 August 2021:

> *'13. I had concerns about staffing at the Home. Staff in the lounge were able to observe residents via a live CCTV link on a large screen. There was no staff member designated to this role, and staff would observe the screen while completing other care tasks. If a staff member observed concerns about safety elsewhere in the Home, the staff member's location in the lounge would mean they could not respond immediately.*

This would leave the resident at prolonged risk of harm. Some residents had 1 to 1 care, and some other staff were often moving around the Home. However, the use of this CCTV system could not be considered a good way of responding to risk escalation as staff were not near the person to respond. We observed it was not effective at mitigating the risks seen on inspection. I would expect the registered person's [sic] *to have recognised the limitations of this system and deployed sufficient staff to keep people safe.'*

You told the panel that the CCTV cameras were installed in 2019, and the reason this was installed was due to occurrences such as residents urinating in the corridor and or removing clothes in different areas in the corridor or acting otherwise inappropriately. You gave evidence that Owner 1 came up with the idea of installing CCTV to give better vision of the corridor. You told the panel that the purpose of the CCTV was to support the staff as an additional aid and was not intended to be continuously monitored by a designated member of staff.

The panel therefore found that the purpose of the CCTV was to act as an additional aid for staff members, and did not require supplementary staffing levels. As such, there was no onus on you to ensure that there were designated staff to continuously monitor the CCTV.

Accordingly, the panel found Charge 3(i) not proved.

In considering Charge 3(ii), the panel went onto consider whether the system of viewing the CCTV footage did not allow for staff members to reach a resident in need in a more remote place. Having considered your evidence that the CCTV was used to help staff and not solely relied on for the care of residents, the panel does not find this charge proved.

Accordingly, the panel found Charge 3(ii) not proved.

Charge 3(iii)

3. Failed to provide adequate staffing levels generally and in particular in that:

(iii) The dependency tool used to calculate required staffing levels was of a poor quality and insufficient to calculate suitable staff levels.

Charge 3(iii) is found proved.

The panel was satisfied that, as the Registered Home Manager, staffing levels fell within your remit. The panel then considered whether you failed to provide adequate staffing levels generally as outlined in Charge 3(iii).

The panel took into account Witness 1's statement to the NMC dated 31 August 2021 which stated:

'16. It is my judgement that the dependency tool used to calculate required staffing levels at the Home on 14 and 15 October 2020 was poor quality and would be insufficient to calculate suitable staffing levels at the care home. The reasons for my judgement are numbered below:

a. People using the Home had been recorded as having 5 possible dependency levels (0, 1, 1.5, 2 and 3). These different dependency levels described how much support these people would need. […]*. When I compared people's dependency tool calculation levels to their actual care needs, I found that they had not been given a correct dependency level.* […]

b. The dependency tool was focused on personal care, meals, repositioning and drinks. It did not consider the further daily needs of a complex client group. […] *There was no time given in the dependency tool calculation to allow staff to support these behaviours that*

challenged them throughout the day. Instead, time was only allocated to meet tasks needed throughout the day – rather than behavioural needs.

c. Although the dependency tool described how many staff minutes were required to support level 1, 1.5 and 2 people. No minutes had been allocated to support people described as level 3. Although people noted as level 3, required one to one support, they still required more than one staff member at times. […] *This would mean there are insufficient hours provided to staff. We had concerns about the amount of staff at the Home and the deployment of staff throughout the home.* […].*'*

You said during your oral evidence:

> *"I want just to mention that was the first time when I saw a dependency tool in my life. I never saw one before, so I don't have any*[thing] *to compare* [it to] *if it's done all right or need more column or need other information. So, I calculate*[d] *based on the information which was already provide*[d] *in the tool."*

The panel also had sight of the dependency tool. It found that the tool was inadequate with a flawed underlying rationale for allocation of staffing numbers. The panel determined that the ad hoc approach was inadequate. Further, by your own admission, you also did not fully understand the logic within the tool, and did not question it at the time. The randomised use of one-to one staffing allocations at specific times was not a plausible reality as residents' needs are ongoing and not just for a few hours. The panel considered that as Registered Manager, you should have researched dependency tools yourself in order to create a robust system to determine adequate staffing levels for the Home.

Accordingly, the panel found Charge 3(iii) proved.

Charge 3(iv)

3. Failed to provide adequate staffing levels generally and in particular in that:

(iv) On the 9th November 2020 there was a failure to employ a replacement nurse for one who had resigned

Charge 3(iv) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, staffing levels fell within your remit. The panel then move onto consider whether you failed to provide adequate staffing levels generally when Colleague 2 resigned.

Witness 2 stated in their statement dated 24 May 2022:

> *'45.* […] *The day before,* [Colleague 2] *had resigned with immediate effect and Giorgiana did not communicate this with anyone. Giorgiana did not arrange agency cover for the medication rounds.'*

You provided the panel with the letter of resignation from Colleague 2 dated 5 November 2020. It stated:

> *'Please accept this letter as formal notification that I am leaving my position with St Augustine's Court Care Home effective the 12th of November'*

You told the panel that Colleague 2 was rostered to work between 5 November 2020 until 12 November 2020, and it was your understanding from his letter that he intended to fulfil his shifts until the day stated in the letter. You then said that you spoke to Owner 1, who arranged for a nurse to come from 12 November 2020, and

as such, it was also a surprise to you when Colleague 2 did not attend his rostered shifts.

In light of your evidence, the panel was satisfied that you did not fail to provide adequate staffing levels following Colleague 2's resignation. When Colleague 2 resigned on 5 November 2020, he gave one week's notice and it was reasonable to believe that Colleague 2 intended to complete his rostered duties until the last day of his employment.

Accordingly, the panel found Charge 3(iv) not proved.

Charge 3(v)

3. Failed to provide adequate staffing levels generally and in particular in that:

(v) You omitted to respond to staff concerns about staffing levels.

Charge 3(v) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, staffing levels fell within your remit. The panel then moved onto consider whether you failed to provide adequate staffing levels generally and, in particular, omitted to respond to staff concerns about staffing levels.

The panel had regard to Witness 5's statement to the NMC dated 29 March 2022 which stated:

> *'7. The NMC asked me about the level of staffing in the Home. Most of the time I felt that the staffing was adequate. However, there were days where I felt like we had staffing issues which I raised with* [Owner 1] *as Giorgiana could not change the staffing levels.* [Owner 1] *would respond with there was a funding issue and the staffing levels were more than adequate.'*

The panel also heard evidence from Dr 1 who stated:

> *"We discussed it on several occasions. There appeared not to be enough staff at nighttime and there was also a discussion about the quality of the staff that worked at nighttime. There was often, I think, three or four people looking after a 40-bed home with one of them being a qualified nurse of sometimes doubtful quality*.[…] *I had several discussions with Georgiana who I know then brought it up with the owners of the nursing home. And I had direct contact with the owners of the nursing home, saying that I thought they were understaffed at night*. […]
>
> […] [Owner 1] *would always be receptive and say that, yeah, it was something that he would look into and that he appreciated that.* […] *but we never saw very much action as a as a result."*

In your oral evidence, you told the panel that Witness 5 had spoken to you about her concerns about the staffing levels at night. You spoke to Owner 1 following this and were informed that Owner 1 was not prepared to increase the numbers. You explained that Owner 1 said that he checked the dependency tool and the numbers were *"okay"* and that Owner 1 did not have the funding to employ more workers. You told the panel that you disputed the charge, as you tried your best with Owner 1 to address the night staffing concerns, however Owner 1 refused to take action regarding this.

The panel therefore found that you listened to staff concerns, and you did raise them to Owner 1, albeit Owner 1 refused to enhance the staffing and your efforts were ineffective.

Accordingly, the panel found Charge 3(v) not proved.

Charge 3(vi)

3. Failed to provide adequate staffing levels generally and in particular in that:

(vi) You omitted to engage in addressing staffing levels and/or reporting concerns to the Home's owner

Charge 3(vi) is found proved.

As in Charge 3(v), the panel considered Witness 5 and Dr 1's evidence in which they directly raised concerns about staffing with Owner 1 and you. Having decided that you responded to such concerns, the panel went onto consider whether you engaged in addressing the staffing concerns and/or reported concerns to the Home's owner.

Having considered the evidence as referenced in Charge 3(v), the panel found that you did raise the concerns regarding staffing levels with Owner 1. However, no further steps were taken following this.

The panel then considered Witness 3's oral evidence in which they stated that as a registered manager with legal responsibility for the safe running of the Home, you should have reported back to the CQC or partner agencies if problems arose. The panel noted that the CQC report from a month previously had not identified issues with inadequate staffing and considered that this may have prevented you from taking the matter further.

However, the panel found that having recognised staffing levels were inadequate and having tried and failed to address this with Owner 1, you still had a legal responsibility to engage in addressing staffing levels by escalating this matter to the relevant agencies to assist you.

Accordingly, the panel found Charge 3(vi) proved in respect of the staffing levels.

Charges 4(i), (ii) and (iii)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
   (i) In relation to Resident H who suffered a seizure on the 2nd November 2020, omitted to intervene and/or provide care.
   (ii) Omitted to provide paramedics with H's medical history
   (iii) On the 25 October and 2nd November 2020, omitted to refer H for a GP review.

Charges 4(i), (ii) and (iii) are found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as in Charges (i), (ii) and (iiii).

In considering Charges 4(i) and 4(ii), the panel had regard to Witness 2's statement to the NMC dated 24 May 2022:

> *'18. On 2 November 2020, Resident H experienced a seizure in the lounge. This was my first day at the Home and I was in the nursing office. The Nurse on duty,* [Colleague 2], *came into the room looking for something. He did not seem to be in a rush and was casually searching the room.* […]. *I asked* [Colleague 2] *what he was looking for and he casually responded observations for as Resident H was not responding*.[…]
>
> *19.I went to the lounge to check on Resident H. Present in the lounge were myself, Giorgiana*, [Colleague 2], [BKRCC Consultant 2] (BKRCC consultant) *and* [Senior Carer 1]. *Giorgiana was by the service hatch and did not appear interested in what was happening with Resident H. The emergency bell had not been used and it seemed like there was no recognition Resident H was experiencing a seizure, staff were trying to*

talk to him. Resident H had different sized pupils, but [Colleague 2] *thought they were the same size. I asked* [BKRCC Consultant 2] *for a second opinion as to whether the pupils were different sizes and she confirmed. I then asked if Resident H had a DNACPR form.* [Colleague 2] *said there was no DNACPR despite the Respect form DNACPR section being signed in paperwork*. […].

20. Resident H regained consciousness and we moved him to a different side of the lounge as he was agitated and had stood up of his own accord. The paramedics arrived and they asked for Resident H['s] medical history, the staff could not answer this. Giorgiana was present in the lounge but she did not come over to ask what happened, why the paramedics had been called or to support the paramedics. I told the paramedic the staff could not give medical history, I told them there was no history of seizures according to the records I had looked at whilst awaiting their arrival. I later discovered this wasn't in fact Resident H's first seizure. As Resident H had improved, and after discussion with his sister, the paramedics decided that although this was his first seizure he would remain at the service, and we should call 999 again if new concerns presented.

21. As I believed it was Resident H['s] *first seizure, I knew a medical review needed to be arranged with the GP within 24 hours, I documented this in the nursing diary. I spoke to Giorgiana and said Resident H needed a medical review due to the seizure earlier. Resident H*['s] *GP was contacted and BKRCC noticed the medical history noted at the Home was not up to date. We then requested further GP summaries for other resdients* [sic] *so that the careplans could be updated.*

22. During the handover for the night shift, [Witness 5] *(Night Nurse) was*

told about the seizure. [Witness 5] *mentioned Resident H had a seizure a week or so ago on 25 October 2020.I produce a copy of the daily notes* […].

23.I would have expected Giorgiana to check if Resident H is ok as she is legally Responsible [sic] *for his care and wellbeing. I would expect Giorgiana to provide the paramedics with the relevant information and follow up with a medical review in the event the nurses did not competently complete either of these tasks. Giorgiana should not have relied on me to deal with the incident. If a seizure had occurred before, Giorgiana should have requested the review earlier and followed up with the GP if the review had not been done. Both* [Owner 1] *and Giorgiana should have ensured documentation was kept up to date by auditing, if Giorgiana could not do it she should have asked* [Owner 1] *to do this.'*

The panel considered your account of the incident during your oral evidence:

"Yes, I remember that day. I was in the office doing assessment over the phone with a manager for a different resident […] *I went in the main lounge to take some folders* […] *when I went out from my office I saw the ambulance.* […] *I met the nurse and I asked him "what happen, why the ambulance is there?"* […] *I went in the lounge and one paramedic was there with* [Senior Carer 1]*,* […] *He said "*[Witness 2] *thinks Resident H had a seizure, so she called the ambulance"* […] *I went in the lounge and I saw the paramedic with* [Senior Carer 1] *there.* […]

I spoke to [Resident H]. *He was watching me and he said 'yes', he was verbally communicative, I didn't notice anything at that point.* […] *I spoke with* [Senior Carer 1] *and with the paramedic. I said "I'm sorry I didn't know you are here. I was in a meeting over the phone". And* [the paramedic] *told me that they received a phone call and describe what they've been told over the*

phone […]. *I gave information about his health condition and about his behaviour and in this time, I instructed* [Senior Carer 1] *to take a screen to put* [on] *one side of the resident to cover that area while he was checked by the paramedic* […] *After I asked the paramedic if you like me to stay there and he said no because the nurse is coming.* […] *After* [Colleague 2] *came, I said to* [Colleague 2]*, "I'll go finish the assessment. If you need any help, let me know.*

[…] *I went back in the office and after I realised I didn't do the folders* […] *when I went back, I saw* [Witness 2] *there,* [I] *went* [and took] *my folders.* [Witness 2] *looked at me- I don't say anything and I went back in my office.*

[…] *At that point,* [Witness 2] *didn't say anything to me, and I don't feel there is any point for me to interfere while they were dealing with the resident. At that stage it wasn't an emergency anymore and to mention to* [Witness 2] *that I spoke with the paramedic. "*

The panel found that Witness 2 and your evidence put forward contrasting perspectives. Having considered both accounts, the panel determined that the timeline of events was as follows:

An incident took place in the lounge involving Resident H, and paramedics were in attendance. You became aware of this incident when you were on your way to the lounge to obtain some folders that were needed in relation to a phone call that you were in the midst of. You encountered Colleague 2 who had left the lounge to obtain Resident H's nursing notes. You saw the paramedics with Resident H and went over to see what was happening. You found Resident H to be responsive and sitting in his chair and there was nothing that concerned you. You spoke to the paramedics and gave them an oral handover of Resident H's history. The paramedic confirmed that you were not needed because Colleague 2 was returning to attend to the situation. You left the lounge to finish your telephone conversation.

At this point, Witness 2 became aware that there was an incident that may require her attention and attended the lounge. You had returned to your office but having forgotten the files that you needed, returned to the lounge again and found that Witness 2 was now present. You felt that there was no need to intervene further given that you had already spoken to the paramedic and there was no longer a need for you to involve yourself in a matter which was being attended by a paramedic, a nurse and a senior carer. The panel determined that Witness 2 had formed the incorrect impression that you were attending the lounge for the first time and was concerned that you had not enquired as to what was occurring.

You had not identified a previous incident on 25 October 2020 to have been a seizure and so did not feel it relevant and necessary to hand this information onto the paramedics.

The panel determined that there was no failure on your part. You gave as much intervention as was required, spoke to the resident and correctly established what was going on. You offered assistance to the paramedics but this was not required.

Accordingly, the panel found Charges 4(i) and 4(ii) not proved.

In relation to Charge 4(iii) in respect of the incident on 2 November 2020 in which it was alleged you omitted to refer Resident H for a GP review, the panel considered the aftermath of the incident. Resident H did not return to the Home having left for the hospital on 2 November 2020, therefore, there was no requirement for you to refer the resident to a GP. The panel was satisfied that that you showed an appropriate response to the incident.

In relation to the alleged event of 25 October 2020 involving Resident H, the panel had regard to Resident H's '*Daily Statement of Wellbeing and Care Delivered'* notes dated 25 October 2020. The entry for the alleged incident as written by you stated:

'19:40: Around 19:25 staff informed had a funny episode, like rolling eyes / shaking [sic] *few sec. Check him BP 165/85 P. 77. Sat 97% t. 36.4°c. Give him* […] *(salbutamol). Appeared fine, talking. Staff aware to monitor him.'*

The panel noted that the above account was supported by Colleague 1's handwritten statement signed 16 November 2020 which stated:

'On the 25th October [Resident H] *was sleeping in the arm chair* [sic] *when he woke up shaking his arms I called his name and he looked at me with his eyes wide open* [sic] *reaching his arms out towards me* [sic] *I came to get gyorgina* [sic] *and explain* [sic] *what I saw* […] [You] *came to check* [Resident H] *took his observations which was normal, was a little breathless so gave his inhaler, was talking asking for a cup of tea and laughing and speaking with us. He also asked for a biscuit. We asked* [Resident H] *he said he was dreaming. Was informed to monitor* […] *was his normal self* [sic] *till we finished shift.'*

You reiterated in your oral evidence that from your clinical experience, Resident H was not experiencing a seizure given the observations that you took. You asked a staff member to monitor Resident H following this and no further incident occurred. As such, you believed that there was no need to contact the GP for a further review.

The panel gave your evidence the appropriate weight and noted that you made the professional observation that Resident H was not having a seizure. The panel considered that Resident H was an established resident of the Home who you saw daily and therefore, you would have had good knowledge of his usual state of health and recognised any significant deviations from this. Therefore, the panel determined that given your professional opinion of the presentation of Resident H, there was no need for Resident H to be referred to the GP for a further review.

Accordingly, the panel found Charge 4(iii) not proved.

Charges 4(iv)(a) and (b)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:

(iv) In relation to Resident E on the 14th and 15th October 2020

(a) Failed to respond to his calls of distress, pain and for an ambulance and

(b) Failed to consider the cause of his pain and the remedy for it.

Charges 4(iv)(a) and (b) are found proved.

The panel was satisfied that, as the Registered Home Manager, you had duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as in Charges 4(iv)(a) and (b).

The panel noted Witness 1's statement to the NMC dated 31 August 2021:

'Resident E

43. On the night of 14 October 2020, I observed Resident E expressing pain with his catheter/penis and repeatedly requesting an ambulance. Resident E was standing in his room wearing just a t-shirt with his penis and catheter on display. The catheter was loose, not strapped to Resident E's leg and appeared taut pulling down. I observed that staff did not respond to Resident E's shout for help despite walking past him repeatedly. Due to the pain Resident E was expressing, I spoke to Giorgiana. Giorgiana advised that Resident E was quite obsessive with his catheter and could pull on it causing pain. Giorgiana advised Resident E was fine and she did not respond to him or check on him.'

The panel also had sight of Resident E's catheter plan dated 17 September 2020.

In your oral evidence, you told the panel that you were made aware of Witness 1's observations of Resident E and informed Witness 1 that the shouting was typical behaviour from Resident E. The panel accepted that some residents with dementia may experience frequent shouting and that this may therefore have constituted normal behaviour. However, the panel noted the entry in Resident E's daily record and your assertion that Resident E had an ongoing issue with his catheter and Urinary Tract Infection ("UTI"). You accepted that you did not immediately go to Resident E to address the concerns raised by Witness 1. Therefore, the panel found that even though Resident E may have normalised behaviour of shouting, it is more likely than not that, given his UTI, Resident E was in distress and in pain and you should have taken action to investigate this further.

Accordingly, the panel found Charge 4(iv)(a) proved.

In considering Charge 4(iv)(b), the panel determined that by failing to respond to Resident E's ongoing issues with his catheter, you were unable to consider his pain and remedy the situation.

Accordingly, the panel found Charge 4(iv)(b) proved.

Charge 4(v)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (v) Omitted to obtain formal medical or pharmaceutical authorisation for the use of crushed medication in the covert administration for residents C and J.

Charge 4(v) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(v).

The panel had regard to Witness 2's statement to the NMC dated 24 May 2022 which stated:

> *'24. On 5 November 2020,* [BKRCC Consultant 2] *discovered Resident C was having their medication crushed without it formally being authorised. Crushed medication is used to give medication covertly because the resident may refuse and it is in the resident's best interest to administer it in this manner. For medication to be crushed, a GP must authorise off licenced use of medication.'*

The panel accepted the above evidence as hearsay in that Witness 2 was reporting an incident allegedly witnessed by BKRCC Consultant 2 who did not provide evidence at this hearing.

You provided evidence that you knew what covert medication was and how it should be administered. You further explained that there was only one resident who was receiving covert medication in the Home at this time and this was not Resident J. Dr 1's oral evidence was that he was confident that you knew the protocol of giving covert medication and that you had been involved in discussion with him regarding this matter for various residents several times.

The panel has heard no other evidence to suggest that you were unaware of the process. The panel found that the NMC has failed to discharge the burden of proof other than the hearsay evidence via Witness 2. It was clear from Dr 1's evidence that you understood the procedure in administering covert medication, and Dr 1, who worked with you had no concerns about such matters.

In respect of the concerns regarding Resident J, the panel found no evidence to suggest that Resident J was on a covert medication plan.

Accordingly, the panel found Charge 4(v) not proved.

Charge 4(vi)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:

(vi) On the 5th November 2020, in the face of Resident E expressing suicidal intent, you ignored advice from BKR Consultant 1 to refer him to a doctor and claimed his behaviour was “normal” or words to that effect.

Charge 4(vi) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(vi).

The panel considered Witness 2’s statement to the NMC dated 24 May 2022:

‘32. In the evening of 5 November 2020, Resident E was displaying suicidal ideation after requesting to speak to a doctor for a few days. Resident E was a younger gentleman with dementia but he had good insight in the moment, though he believed we were abroad where he had worked for many years. Resident E had suicidal ideation and he was fixated about causing himself harm/ending his own life. […]’

You disputed the date of this incident and alleged that this in fact took place on 9 November 2020. Apart from Witness 2’s account, the panel had insufficient evidence

before it to dispute your account of the date and accepted that the incident took place on 9 November 2020.

The panel went onto consider the rest of the charge and whether in the face of Resident E expressing suicidal intent, you ignored advice from BKRCC Consultant 1 to refer him to a doctor and claimed that Resident E's behaviour was normal. You provided the panel with your account of the event. You told the panel that Resident E's expressions of intent to commit suicide was part of his habitual behaviour occurring at least two to three times a week. At the time of the event, he was prescribed anti-depressants and also taking antibiotics for a UTI which had increased his confusion. Resident E had asked to speak to Witness 2 and you continued with your duties. You eventually rejoined the conversation as you observed from Resident E's gesticulation that he was becoming distressed. You told the panel that he had been reviewed by the Dementia Outreach Team on 22 and 25 October 2020 and the GP had also reviewed him recently and was therefore aware of his behaviour. You told the panel that there was no need for a further GP referral as Resident E's medication had recently been increased by Dr 1 and therefore needed time to take effect.

The panel had regard to the document titled *'Professional Visitor Record'* which recorded the call with Dr 1. The entry dated 6 November 2020 stated:

> *'Reason for Call:*
> *Re: suicidal thoughts, low mood. Dr said mirtazapine was increased 2 weeks ago. To give more time to have effect'*

Your account was supported by Dr 1's evidence. Dr 1 stated in his oral evidence in respect of Resident E:

> *"We discussed intent what he was intending to do and his intention was mostly that he was unhappy in a nursing home and would rather be at home*

without any plans or ideas of how he would go about killing himself. Which is clinically thought to be unlikely that they have real suicidal intention.

[…] *I'd seen him a few times and discussed his case several times with both Georgiana and the dementia outreach team. I read their reports.* […]

[…] *From memory, when I had the actual discussion with him, I said,* […] *"you're telling the staff and members of your family regularly that you want to die and that you're going to kill yourself". And he seemed to be unable to remember occasions when he'd done that, although he did say that he did recall making comments but couldn't tell me when or how often or anything like that"*

In light of the above evidence, the panel found that Witness 2 was largely unfamiliar with Resident E's usual behaviour. It noted that Witness 2 only attended the Home on an infrequent basis, and as such, Witness 2 may at times have queried the professional opinion of the manager of a failing care home. The panel noted that it was not unreasonable for Witness 2 to have concerns when faced with Resident E who appeared to demonstrate suicidal ideation. The panel heard from Dr 1, who was familiar with Resident E; he explained the difference in risk between suicidal intention and ideation. The panel also considered your evidence and knowledge of Resident E and was satisfied that your rationale for not referring Resident E to a doctor was the proportionate and appropriate action, particularly as you had been given instructions to give the Mirtazapine time to take effect.

Accordingly, the panel found Charge 4(vi) not proved.

Charge 4(viii)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:

(viii) Omitted to monitor and/or audit the ordering and signing for medication at the Home.

Charge 4(viii) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(viii).

The panel had regard to Witness 2's statement to the NMC dated 24 May 2022:

> *'45.*[…] *I also discovered there was no real system for ordering medication and signing the medication in at the Home, I discovered this from multiple residents having missing medication.'*

The panel understood the above statement to be the NMC's sole evidence for Charge 4(viii).

You gave evidence that there was a system but you felt confused about your duties once BKRCC were brought into the Home. You explained in your oral evidence your knowledge of the usual process for checking medication and auditing medication and prescriptions at the Home:

> *"We collect the prescription. After, we compare the prescription with the MAR chart to see what medication we need and we were able to write the amount of the medication.* […] *So, after everything was checked, the prescription went to the pharmacist and the pharmacist would send the medication. If you couldn't find a medication, we just record and contact the pharmacy to inform them "you didn't send the medication for this resident"."*

You told the panel that there was an incident in which you were told by Witness 2 and members of BKRCC that you were not allowed to order or check medication. This therefore caused confusion whilst BKRCC was at the Home. You further stated that you conducted a medication audit every month as it was not possible or reasonable to order medication every day.

The panel found that the NMC has not discharged its burden, as there was no evidence other than Witness 2's account to support the charge. The panel found that it was evident that the presence of BKRCC caused confusion as to who was in charge of routine tasks. Due to the insufficient evidence before it, the panel does not find this charge proved.

Accordingly, the panel found Charge 4(viii) not proved.

Charge 4(ix)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (ix) On the 9th November 2020, when Resident O was being transferred to another home, failed to ensure that her medication accompanied her.

Charge 4(ix) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(ix).

The panel noted that Witness 2's statement to the NMC dated 24 May 2020 stated:

'42. Resident O was missing her lorazepam, paracetamol, used to treat pain or high temperatures, crepe banadage [sic]*, used to dress her wounds,*

macrogol, to treat constipation, and co-amoxiclav, an antibiotic which was still meant to be provided to her. Lorazepam is used to treat anxiety and depression, it was an important medication for Resident O. Giorgiana said the missing medication had ended for Resident O. [BKRCC Consultant 2] *called the GP who confirmed that the medication had not been ended. The GP issued a new prescription for Resident O for all the medication that was missing.'*

The panel had sight of the MAR Chart for Resident O which appeared to have start dates for 12 October 2020, 16 October 2020 and 19 October 2020. It was your evidence that the other medication outlined in the MAR Chart sheet were no longer required, and as such, Resident O was transferred with just the Epimax.

Dr 1 stated during oral evidence:

"I've had a conversation with Georgiana to clarify it using the notes […]. *It's sometimes not clear what's actually happening just from the notes and what happened in that instance was the lady was on some medication and it was discontinued just before the transfer. And so there may have been some confusion about that. And in retrospect, when you look at through all the facts, it looks like they had been stopped at the time of transfer. It is possible that that BKR had a conversation with one of us. I don't think it was me."*

The panel, having considered your evidence and that of Witness 2 and Dr 1, determined that the documentation regarding the actual medication that Resident O was on was unclear. However, it is clear from Dr 1, who was the Residents' doctor during this period, that the only medication required for Resident O was Epimax, and any other medication was not a repeat medication and no longer needed.

Accordingly, the panel found Charge 4(ix) not proved.

Charge 4(x)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
        (a) Unattended and/or unlocked medication trolleys
        (b) Unattended and/or open medication racks.

Charges 4(x)(a) and (b) are found proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went on to consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charges 4(x)(a) and (b).

The panel took into account Witness 2's evidence in which she provided photographs taken from her work phone of an unattended and/or medication trolleys and unattended and/or opened medication racks.

The panel had sight of your reflective account form in which you stated:

> *'The trolley was in nurse station* [sic]*, the gate was locked but the trolley door was opened. I asked the Team Leader to stay there and monitor my trolley to ensure the resident doesn't have access and I went to give to* [sic] *a resident his medication prescribed* […]
>
> *In that time* [sic] *I was tired, very stress with all things* [sic] *which was happening in the care home. We had care inspection; care home closing down, BKR was in the building. I did not feel any support from BKR. The Director wasn't allowed to come into the building. I felt* [sic] *lot of pressure on*

my shoulder. Nobody was affected as I gave instruction to the Team Leader to stay and observe the trolley'

The panel also heard from Witness 8 during oral evidence that there had been occasions in which she had asked Senior Carer 1 to keep an eye on the trolley. The panel noted that this appeared to be a practice at the Home.

The panel noted that whilst there was contrasting evidence between Witness 2 and your evidence in respect of Charge 4(x)(a), the panel made an inference that the practice at the Home was not stringent in regards of the medication trolley. Residents could have gained access to the opened medication trolley in the event it was unattended or not properly observed.

Accordingly, the panel found Charge 4(x)(a) proved.

In respect of Charge 4(x)(b), the panel had sight of photographs taken and exhibited by Witness 2 in which unattended medication racks were clearly visible. The panel took the view that there was a very lax approach in medication practice at the Home.

Accordingly, the panel found Charge 4(x)(b) proved.

Charge 4(x)(c)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
        (c) MAR charts lacking 2 signatures when you were tasked with charting.

Charge 4(x)(c) is found proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(c).

The panel understood this charge to be concerned with the signatures that should be on MAR charts when medication is received and dispensed to patients.

The panel took into account Witness 2's statement to the NMC dated 24 May 2022 in which they described selecting MAR charts and found only one member of staff had signed the chart despite the medication being administered by you and Witness 8.

In your oral evidence, you told the panel that you accepted that when medications are administered by two staff members both signatures are required on the MAR chart.

The panel therefore found, having considered the documentary evidence, Witness 2's evidence and your agreement that some of the MAR charts should have contained two signatures, that Charge 4(x)(c) is proved.

Accordingly, the panel found Charge 4(x)(c) proved.

Charge 4(x)(d)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
    (d) Pre-potting along with previous crushed medication.

Charge 4(x)(d) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(d).

The panel carefully considered the wording of subsection (d) and found it to be ambiguous. It noted Witness 2's statement to the NMC dated 24 May 2022 in which they assert the risk of cross contamination. However, in Witness 2's oral evidence to the panel, they confirmed that they had not seen you personally crushing medication and the panel took the view that this was an assumption.

The panel has not seen any evidence from the NMC which, firstly, clarifies the mischief in the charge, and secondly, evidence to support the charge. Whilst there was ample photographic evidence of the other concerns, there was nothing before the panel to evidence *'pre-potting with previous crushed medication'.*

Accordingly, the panel found Charge 4(x)(d) not proved.

Charge 4(x)(e)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
        (e) Putting tissue paper in medication pots.

Charge 4(x)(e) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(e).

The panel had sight of the photographic evidence exhibited by Witness 2 which shows a transparent plastic cup containing blue tissue paper and a handwritten piece of paper which allegedly contained the name of a resident.

You told the panel that this was a piece of rubbish that Witness 8 had asked you to hold during a medication round. Your account was supported by Witness 8's oral evidence in which they said that they asked you to hold the cup containing litter, as they intended to complete their charting later and the piece of paper containing the resident's name was merely an aid to help Witness 8 remember to whom they gave the medication.

The panel noted that the photograph taken by Witness 2 did not show that there was any medication inside the pot. The panel therefore preferred Witness 8's and your evidence in that the cup shown in the photograph was litter due to be discarded.

Accordingly, the panel found Charge 4(x)(e) not proved.

Charge 4(x)(f)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
        (f) Unhygienic storage of a kidney dish with tweezers and packs.

Charge 4(x)(f) is found proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went on to consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(f).

The panel noted Witness 2's statement to the NMC dated 24 May 2022 which stated:

> '*47. There was also a kidney dish with tweezers and dressing packs not stored in a clean and hygienic way. Whilst infection prevention control was a concern for me at this point, I was really concerned with the poor medication practice.'*

Witness 2 further stated in oral evidence that the kidney dish, tweezers and dressing packs had been in the same position for four days.

You told the panel during your oral evidence that you did not know why these items were there. You said that these items are usually stored in the clinical room.

The panel considered that this charge is not in dispute. Whilst the panel accepted that you had no knowledge of why the items were not in their usual storage, the panel determined that it was still within your duty to ensure that these items remained in their rightful storage and once opened, tweezers and packs should be discarded to avoid the risk of infection.

Accordingly, the panel found Charge 4(x)(f) proved.

Charge 4(x)(g)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
        (g) MAR charts with medication out of stock

Charge 4(x)(g) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(g).

The panel considered the documentary evidence before it, including Witness 2's statement to the NMC dated 24 May 2022 which stated:

> *'There was MAR charts with medication out of stock and I found this alarming. Giorgiana was not checking medication stock and ordering what is required or ensuring the nurses did so.'*

Whilst the panel had sight of some MAR charts, the panel did not find evidence to clearly identify from the MAR charts which medication, if any, was out of stock. The panel determined that the NMC had not provided sufficient evidence and had not discharged the burden of proof to support the charge.

Accordingly, the panel found Charge 4(x)(g) not proved.

Charges 4(x)(h)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
    (h) Multiple pots being dispensed at the same time

Charge 4(x)(h) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then

went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(h).

The panel had regard to Witness 2's evidence to the NMC dated 24 May 2025 which stated:

> *'51.I then monitored the lunchtime medication round. Giorgiana adminsitered* [sic] *the medication on her own. Giorgiana potted medication as before and took multiple pots with her whilst she administered medication.'*

However, the panel has not seen sufficient evidence, except for Witness 2's account, to support the charge and determined that the NMC had not provided sufficient evidence and had not discharged the burden of proof to support the charge.

Accordingly, the panel found Charge 4(x)(h) not proved.

Charge 4(x)(i)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
        (i) Dispensing medication yourself while another administered it and vice versa

Charge 4(x)(i) is found proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge (4)(x)(i).

The panel had regard to Witness 2's evidence of her observations in that you or another nurse would dispense medication, whilst another administered the medication.

The panel noted that you agreed that this took place. However, the panel determined that this was not necessarily unsafe practice, as the correct medication was given to the right patient. In your oral evidence, you explained that if a resident was refusing medication but being acquiescent with another member of staff, you may then ask that staff member to give the medication under your supervision. Nevertheless, the panel found that your actions of sometimes allowing another person to administer the medication that you had dispensed was proved as detailed in the charge. It concluded that, although this may sometimes have been a rational course of action on occasions, both signatures of those involved should have been recorded and not doing this was poor medication practice.

Accordingly, the panel found Charge 4(x)(i) proved.

Charge 4(x)(j)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
        (j) Lack of ID sheet to identify resident to whom administration intended.

Charge 4(x)(j) is found NOT proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice.

The panel had regard to your oral evidence in which you explained in detail the medication folder. You said that the folder contained a front sheet with the resident's

picture, date of birth, allergies and the type of drink and/or food they could consume. You told the panel that you do not often use this as you were familiar with the residents at the Home.

In light of your evidence, and a lack of evidence from the NMC to discharge the burden of proof, the panel found that there was insufficient evidence to support this charge.

Accordingly, the panel found Charge 4(x)(j) not proved.

Charge 4(x)(k)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
    (k) Trolleys left with both doors open

Charge 4(x)(k) is found proved.

The panel considered that the evidence for this charge is the same as those referred to in Charges 4(x)(a) and (b). As such, the panel found that trolleys were left with doors open and unattended which clearly demonstrates poor medication practices.

Accordingly, the panel found Charge 4(x)(k) proved.

Charge 4(x)(l)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
    (l) Resident J had medication crossed off without dates.

Charge 4(x)(l) is found proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(l)

The panel had sight of the MAR chart for Resident J and noted that there were lines across four of his ten prescribed medications to indicate *'discontinued'.* However, for two of these, there was no date as to when and by whom these had been stopped and no reason given. The panel noted that professionals viewing this MAR chart might have been confused and this could have an adverse impact on the care for the resident.

Accordingly, the panel Charge 4(x)(l) proved.

Charge 4(x)(m)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
    (m)In Resident B's case, you omitted to action expiry of GKN spray timeously

Charge 4(x)(m) is found NOT proved.

The panel interpreted this charge to be referring to Glyceryl Trinitrate ("GTN").
The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(m).

The panel considered Resident B's MAR chart as supplied by Witness 2. The panel saw no evidence of *'GKN spray'* (or GTN) being prescribed to Resident B.

The panel determined that the NMC has not provided sufficient evidence and discharged the burden of proof to support this charge.

Accordingly, the panel found Charge 4(x)(m) not proved.

Charge 4(x)(n)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
    (n) In Resident [M]'s case, dates were missing for administration of drugs and when last given.

Charge 4(x)(n) is found NOT proved.

The panel carefully considered this charge and found no evidence in either the documentary materials or oral evidence that refers to this charge and this resident.

In light of the insufficient evidence before the panel, it determined that the NMC has not discharged the burden of proof.

Accordingly, the panel found Charge 4(x)(n) not proved.

Charge 4(x)(o)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely

(o) You omitted discussion with the doctor in relation to the continuance of medication in Resident O's notes.

Charge 4(x)(o) is found NOT proved

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice.

The panel heard oral evidence from Dr 1 regarding this charge:

> *"I've I had a conversation with Georgiana to clarify it using the notes* […]. *It's sometimes not clear what's actually happening just from the notes and what happened in that instance was the lady was on some medication and it was discontinued just before the transfer. And so there may have been some confusion about that. And in retrospect, when you look at through all the facts, it looks like they had been stopped at the time of transfer. It is possible that that BKR had a conversation with one of us. I don't think it was me."*

The panel considered the documentary evidence by the NMC. Whilst the panel has been provided with the MAR charts for Resident O, the panel took the view that this has not sufficiently established what date this incident pertains to and has not provided sufficient evidence to support the charge.

Accordingly, the panel found Charge 4(x)(o) not proved.

Charge 4(x)(p)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
   (x) In or about November 2020 omitted to prevent poor medication practices, namely

(p) Body maps lacked dates, follow up and progression of wounds.

Charge 4(x)(p) is found proved.

The panel was satisfied that, as the Registered Home Manager, you had a duty to provide adequate and/or safe healthcare and/or safe medication practice. It then went onto consider whether there was a failure to provide adequate and/or safe healthcare and/or safe medication practice, as outlined in Charge 4(x)(p).

The panel had sight of the body maps for different residents. This included Resident B (date completed 31 October 2020), Resident O (date completed 28 October 2020), and Resident D (date completed 11 November 2020).

Mr Buxton asked Witness 2 during cross examination whether the dates which stated *'date completed'* was indicative of when the body maps were completed. Mr Buxton referred the panel to Resident B's body map. Witness 2 responded:

> *"I disagree. There are multiple dates on which this has been completed and I know that because we've got under the description of injury and bruise, which is under the second box on the form, no injuries or bruises on the body has been crossed* out […] *I suspect that the old bruise is underneath the old bruising on both hands, which is a different description. If we move down to the colour- green/yellow from my haematology experience and elderly care experience is an old bruise- typically one that's at least five to seven days old, depending on the ageing and skin integrity of the individual. A purple bruise, by contrast, is usually one within 24 hours old so these are multiple different entries on the same form, but it gives me no ability to track how any of these wounds are healing or where any of them have come from. What size any of them are. And these are all essential pieces of detail for anybody."*

Having seen the quality of these body maps, the panel was unable to deduce from the evidence as to when such bruises were formed. The body maps were of poor quality and lacking in detail which could have affected future medical care for the relevant individual. The panel considered that, as Registered Manager, it was your responsibility to ensure that all staff knew how to accurately complete and date body maps.

Accordingly, the panel found Charge 4(x)(p) proved.

Charge 4(x)(q)

4. Failed to provide adequate and/or safe healthcare and/or safe medication practice:
    (x) In or about November 2020 omitted to prevent poor medication practices, namely
    (q) There were discrepancies between the nursing and medical notes.

Charge 4(x)(q) is found NOT proved.

In considering this charge, the panel determined that it received no clear direction or evidence from the NMC to establish what documentary evidence this charge relates to and therefore the NMC has not provided sufficient evidence and has not discharged the burden of proof to support this charge.

Accordingly, the panel found Charge 4(x)(q) not proved.

Charges 5(i)(a), (b), and (c)

5. Failed to provide adequate care plans and/or clinical notes in that you:
    (i) On the 14th and/or 15th October 2020, after Resident E complained of pain, omitted to create an appropriate catheter care plan and/or failed

generally thereafter prior to the 27 October 2020 to adequately update the catheter care plan.

(a) You did not mention the strap for the catheter needed to be attached to the thigh
(b) You provided different time scales for the changing of the catheter.
(c) You did not provide any guidance as to blockages and/or infection.

Charges 5(i)(a), and (c) are found proved.
Charge 5(i)(b) is found NOT proved.

The panel considered the stem of the charge and understood that in order to find this charge proved, it must find that you had the duty to provide adequate care plans and/or clinical notes. The panel, having been satisfied that you are the Registered Home Manager, found that you had a duty to your residents in that you had a duty to provide adequate care plans and/or clinical notes. It then went onto consider whether there was a failure to provide adequate care plans and/or clinical notes, as outlined in Charges 5(i)(a), (b), and (c).

The panel considered Witness 1's statement to the NMC dated 31 August 2021:

'49. On 16 October 2020 we flagged the above catheter risks in our letter of intent. The response was that catheter care training would be arranged. […] *The response did not state how the care plan would be improved. When we returned on 27 October 2020, I reviewed the catheter care plan again.*

50. It had been updated by Giorgiana however the update was poor quality. It did state that the catheter should be anchored to the thigh. However there were other concerns. The care plan stated the bag should be

changed as per training 'At least every 4 days'. This was in contradiction to the 'catheter bundle' document which was to change 'every 5 to 7 days'. There was no guidance in care plan about how to spot signs of infection/blockages or what to do if Resident pulled the catheter out.'

In Witness 1's oral evidence, she further reiterated that there was a general lack of knowledge on catheter care at the Home. This was supported by Witness 4's evidence who observed Colleague 2 and also came to the opinion that there was a lack of guidance and knowledge on catheter care.

In your oral evidence, you told the panel that you were inexperienced when it came to catheterisation. You said that when Resident E returned to the Home following a hospital visit, he was already catheterised. You said that you asked Owner 1 for training. This training was scheduled to take place on 23 October 2020.

The panel determined that it was clear that you and the Home staff were inexperienced when it came to catheter care. Within the updated catheter plan, you failed to mention that the strap for the catheter needed to be attached to the thigh, provided different time scales for the changing of the catheter and you did not provide any guidance as to blockages and/or infection. As such, the panel determined that the updated care plan lacked specific information that one may require when dealing with catheter care. The panel noted that such information was not wilfully omitted but rather due to your inexperience with catheter care.

Accordingly, the panel found Charges 5(i)(a), and (c) proved.

With regards to Charge 5(i)(b), the panel drew a distinction between a catheter bag and the catheter itself. For this charge, the panel considered the catheter in line with the wording of the charge. The panel noted the catheter care plan exhibited by Witness 1, where reference is made to changing the catheter on two different documents. The care plan dated 17 September 2020 refers to changing the catheter

every 10 to 12 weeks and an undated updated care plan refers to changing the catheter every 12 weeks. The panel did not consider these timescales materially different. Therefore, the panel found Charge 5(i)(b) not proved.

Accordingly, the panel found Charge 5(i)(b) not proved.

Charges 5(ii)(a), (c) and (d)

5. Failed to provide adequate care plans and/or clinical notes in that you:
    (ii) In or about September 2020, omitted to provide Resident A with an appropriate care plan and failed adequately thereafter prior to the 27 October to review and update the care plan in that
        (a) The low bed was not mentioned in the care plan
        (b) […]
        (c) There was no risk assessment nor one for Resident A's understanding of the risk.
        (d) One hourly checks directed by the plan could not meet the risk.

Charge 5(ii)(a) is found NOT proved.
Charge 5(ii)(c) is found PARTIALLY proved.
Charge 5(ii)(d) is found proved.

The panel, having been satisfied that you were the Registered Home Manager, found that you had a duty to your residents to provide adequate care plans and/or clinical notes. It then went onto consider whether there was a failure to provide adequate care plans and/or clinical notes, as outlined in Charges 5(ii)(a), (c) and (d).

In considering Charge 5(ii)(a), the panel took into account Resident A's care plan as exhibited by Witness 1, and the updated care plan provided by you dated 17 October 2020. The panel noted that the care plan exhibited by Witness 1 does not mention the low bed. However, in the updated care plan, it stated:

‘At the present she’s having in situ a low bed which is near the crash mat and in top of the crash mat a sensor alarm to alert the staff in case if […] *is rolling out from bed’*

In light of the above extract from Resident A’s care plan, the panel found Charge 5(ii)(a) not proved.

In considering Charge 5(ii)(c), the panel had regard to Witness 1’s statement to the NMC dated 31 August 2021:

’27 […] *There was no risk assessment or evidence that Resident A’* [sic] *understanding of this risk had been assessed. One hour checks guided in the care plan would also not mitigate this risk.’*

In your evidence, you provided the panel with the updated care plan dated 17 October 2025 which stated:

‘MCA [Mental Capacity Act] *and Best Interest completed’*

The panel found that the narrative in the updated care plan for Resident A did detail some of the risks associated with this resident but the panel found that this was insufficient to meet the threshold for being an adequate risk assessment.

Accordingly, the panel found Charge 5(ii)(c) partially proved.

In considering Charge 5(ii)(d), the panel again noted that the original care plan that was exhibited by Witness 1 did not mention the low bed and the assistive technology. As such, given the significant risks identified regarding Resident A, the panel determined that one-hour checks would not have sufficiently mitigated the risk of harm.

Accordingly, the panel found Charge 5(ii)(d) proved.

Charge 5(iii)

5. Failed to provide adequate care plans and/or clinical notes in that you:
   (iii) Omitted to ensure that Resident B's care plans included his problematic behaviours, the triggers for those problems and the action needed.

Charge 5(iii) is found proved.

The panel, having been satisfied that you were the Registered Home Manager, found that you had a duty to your residents in that you had a duty to provide adequate care plans and/or clinical notes. It then went onto consider whether there was a failure to provide adequate care plans and/or clinical notes, as outlined in Charges 5(iii).

The panel had regard to Witness 6's evidence which included Resident B's care plan which had been updated on 22 July 2020:

> *'*[Resident B] *is diagnosed with Dementia-Korsakoff. He is very confused which makes him unable to maintain his own safety inside and outside of the building.*
>
> [Resident B] *has a history of verbal and physical aggression such as he can push, punch the staff and residents.*
>
> *He depends totally on staff to maintain a safe environment. Resident B is on 24 hour 1:1 due to very high risk challenging behaviour.'*

The panel then considered the care plan which you provided dated 18 September 2020 which provides no mention of Resident B's triggers for his problematic behaviour. The

panel found that such an omission was significant because of the risk of harm that it posed not only to Resident B but to the staff and fellow residents.

Accordingly, the panel found Charge 5(iii) proved.

Charge 6(i)

6. Failed to provide adequate training of staff in that you:
    (i) Omitted to provide up to date documentation on Resident H's medical seizure care to allow staff to assess him appropriately.

Charge 6(i) is found NOT proved.

The panel had regard to the stem of the charge. Having noted that, as a Registered Home Manager, you had a duty to provide adequate training to the staff at the Home.

The panel noted that the evidence for this charge relate to the event which took place on 25 October 2020, the panel had regard to Resident H's '*Daily Statement of Wellbeing and Care Delivered'* notes dated 25 October 2020. The entry for the alleged incident, as written by you, stated:

> *'19:40: Around 19:25 staff informed had a funny episode, like rolling eyes / shaking* [sic] *few sec. Check him BP 165/85 P. 77. Sat 97% t. 36.4°c. Give him* […] *(salbutamol). Appeared fine, talking. Staff aware to monitor him.'*

In Colleague 1's handwritten statement signed 16 November 2020 of their account of the incident, it stated:

> *'On the 25th October* [Resident H] *was sleeping in the arm chair* [sic] *when he woke up shaking his arms I called his name and he looked at me with his*

eyes wide open [sic] *reaching his arms out towards me* [sic] *I came to get gyorgina* [sic] *and explain* [sic] *what I saw* […] [You] *came to check* [Resident H] *took his observations which was normal, was a little breathless so gave his inhaler, was talking asking for a cup of tea and laughing and speaking with us. He also asked for a biscuit. We asked* [Resident H] *he said he was dreaming. Was informed to monitor* […] *was his normal self* [sic] *till we finished shift.'*

The panel previously found in Charge 4(iii) that you did not believe that the incident on 25 October 2020 with Resident H was a seizure. The panel determined that it is clear in the daily notes that you carried out the appropriate response to your professional clinical assessment by directing Colleague 1 to monitor Resident H.

Accordingly, the panel found Charge 6(i) not proved.

Charges 6(ii), (iii) and (iv)

6. Failed to provide adequate training of staff in that you:

(ii) Omitted to train staff in the safe care, maintenance and securing of catheters.

(iii) In November 2020, omitted to train and/or guide staff how to wear PPE during the covid pandemic.

(iv) Omitted to provide adequate training in the management of challenging behaviour.

Charge 6(ii) is found proved.
Charge 6(iii) is found NOT proved.
Charge 6(iv) is found NOT proved.

The panel had regard to the stem of the charge. Having found that, as a Registered Home Manager, you had a duty to provide adequate training to the staff at the Home.

The panel next went onto consider whether you failed to provide adequate training as outlined in Charges 6(ii), (iii) and (iv).

In considering Charge 6(ii), the panel had sight of the training matrix which showed that catheter training had not taken place. Further, you told the panel that this was a wider issue in the Home, not just for Colleague 2 but even for you as it had been a long time since you *"did catheterisation".* The panel noted that training was scheduled shortly after the CQC's visit.

In light of your evidence, the panel determined that it would not be unusual for staff members to receive training on catheters and considered this as part of the fundamental skills of a nurse, particularly in a care home such as St Augustine. The panel found that regular training should have taken place for staff members to maintain their skills.

Accordingly, the panel found Charge 6(ii) proved.

In considering Charge 6(iii), the panel noted that the sole evidence in which the NMC relied on was hearsay. The panel has not seen any first-hand evidence to support this charge. Furthermore, it was unclear whose responsibility this would have been in 2020. You were notified on 13 November 2020 that you were no longer the Registered Manager and prior to this had been told to stop clinical duties. The panel therefore determined that the NMC has not discharged the burden of proof to support this charge.

Accordingly, the panel found Charge 6(iii) not proved.

In considering Charge 6(iv), the panel considered the training matrix which contained the heading *'Challenging Behaviour.* This exhibit matrix showed that 79% of staff members had received training on '*Challenging behaviours'.* Witness 7 stated in their oral evidence in respect of the training:

"I'm not sure that it was particularly adequate or appropriate […] *we started taking on very large numbers of people with very challenging behaviour, but* [Owner 1] *would not listen. Giorgiana was also saying this to him* [and] *quite frequently the staff need better training in dealing with challenging behaviours and he wouldn't listen because it would have cost him money."*

Witness 6 stated in his statement to the NMC dated 12 August 2024:

'12. With reference to staff being unable to learn preventative and de-escalation techniques, I found that the training for several staff members was out of date. Refresher training had not been scheduled; therefore, the staff were effectively making it up as they went along.'

During your oral evidence, you explained what training the staff received on challenging behaviour and listed examples of what was learned such as de-escalation and passive restraint techniques.

Having heard that the Home had patients with complex conditions such as dementia, the panel noted that a potentially higher level of training is required to deal with these kinds of behaviour. Training was requested by you but refused by Owner 1. The panel acknowledged Witness 7's evidence that the same level of training existed for challenging behaviour even when the Home took on residents with extremely challenging behaviour who could not be managed in other residential homes. The panel has not seen evidence that training was reviewed or evolved to meet the level of residents.

Whilst there is evidence that training on the management of challenging behaviour was provided, there is no evidence that the training was reviewed and increased when the Home took on more extremely challenging residents. You recognised the need for more specialist training and made unsuccessful attempts to persuade Owner 1 to provide more appropriate training. However, the panel was not provided with objective evidence as to what would have been adequate for the circumstances.

The panel noted that any training that the staff did receive was supplemented by the attendance of the Dementia Outreach Team on a regular basis. This team are expert in their field and one of their roles is to provide advice and guidance on how to manage challenging behaviours for individuals. Whilst this would have been useful, it may not have directly benefited all staff as it was done on an individual basis.

The panel found that the NMC has not discharged the evidentiary burden as the NMC has not established what was considered as adequate training for the circumstance or why the training provided was inadequate.

Accordingly, the panel found Charge 6(iv) not proved.

Charge 7

7. Failed to provide an adequate safe and risk-free environment in that you:

Prior to considering the sub charges for Charge 7, the panel first considered the stem of the charge in that, as a Registered Home Manager, you had a duty to provide an adequate safe and risk-free environment. However, the panel determined that it was impossible to create a *'risk-free environment'* at the Home but instead focused on whether there was a failure to provide an adequately safe environment.

Charges 7(i) and (ii)

7. Failed to provide an adequate safe and risk-free environment in that you:
   (i) Left the kitchen hatch open (with access to knives) when one of the Residents [E] was expressing suicidal intent
   (ii) Individual needs were not described in Personal Emergency Evacuation plans.

Charge 7(i) is found NOT proved.

Charge 7(ii) is found proved.

In considering Charge 7(i), the panel considered Witness 2's oral evidence in that the hatch was open during mealtimes and sometimes opened outside of the active mealtimes. It also considered your oral evidence in that you said that the knives were stored on the far side of the kitchen and that if the hatch was opened, it was likely that the kitchen staff were in the kitchen because the hatch could only be opened from the inside. You also stated that due to the height of the hatch, a chair would be required if one was to attempt to climb through it. Dr 1 also confirmed that the hatch was at *"chest height".*

The panel considered whether the opened hatch posed a risk to Resident E in light of his suicidal ideation.

The panel bore in mind Dr 1's oral evidence:

> *"We discussed intent what he was intending to do and his intention was mostly that he was unhappy in a nursing home and would rather be at home without any plans or ideas of how he would go about killing himself. Which is clinically thought to be unlikely that he had real suicidal intention."*

The panel found that Dr 1 was very clear about his professional opinion of Resident E and that he expressed suicidal ideation rather than having suicidal intent. It noted that Dr 1 was familiar with Resident E and Resident E's condition and it can be inferred from Dr 1's observations that it was unlikely that Resident E would attempt to climb the hatch, particularly as the panel also heard evidence that Resident E was *"severely disabled"*. The panel therefore found that this did not amount to a failure to provide an adequate safe environment.

Accordingly, the panel found Charge 7(i) not proved.

In considering Charge 7(ii), the panel had regard to Witness 3's statement to the NMC dated 17 August 2021:

> *'d. Fire safety: we had reviewed the Personal Emergency Evacuations Plans ("PEEPS") for all residents, these did not describe individual needs and how many staff members were require for a safe evacuation.'*

The panel had sight of Personal Emergency Evacuation Plans ("PEEPS") for five residents. It had particular regard to Resident B's PEEPS which stated that in the event of a time critical evacuation, *'walk with* [Resident B] *to* [a] *safe location'.*

The panel also heard evidence from Witness 6 that the PEEPS had not been made available during the unplanned inspection on 14/15 October 2020, and that when it was made available, there were deficiencies in the PEEPS in the form of insufficient personalised information.

You accepted that the PEEPS needed updating and said that you had done so. However, this was not subsequently inspected by the CQC on the second visit on 27 October 2020.

The panel determined that had it not been for the concerns raised by the CQC these PEEPS would not have been updated. Therefore, by not updating the PEEPS, this would have created a risk of harm to the residents should there be a need for an emergency evacuation.

Accordingly, the panel found Charge 7(ii) proved.

Charge 7(iii)

7. Failed to provide an adequate safe and risk-free environment in that you:
   (iii) Permitted the home to contain hazards

(a) Accessible razors
(b) Fabric of chair breached to create infection control risk
(c) Blocked exterior fire exit
(d) Broken window
(e) Combustible materials along walkway
(f) Expired food
(g) Padlocked gate preventing evacuation
(h) Password stuck to computer
(i) Cubicle in which medication trolley kept unlocked.
(j) Suicide-risk Resident S not having a call bell
(k) Broken toilet and roll holder.
(l) Apron cord out as ligature risk
(m) Food open without note when opened.

Charges 7(iii)(a), (e), (f), (j), (l) and (m) are found NOT proved.
Charges 7(iii)(b), (c), (d), (g), (h), (i) and (k) are found proved.

In considering Charge 7(iii) in its entirety, the panel gave regard to the word *'permitted'* its ordinary meaning of *"allowed"*. The panel then went onto consider whether you permitted the Home to contain hazards when you knew, or ought to have known, that the hazards were there. The panel noted that Witness 2 said that all photographs relevant to the Charge 7(iii) were taken on Witness 2's first day at the Home on 2 November 2020.

The panel first considered Charge 7(iii)(a) and had sight of the photographic evidence provided by Witness 2. Witness 2 attested that this photograph was taken in the lounge of the Home. The photograph was of a wooden cabinet which contained a single razor, and underneath an opened pack of a set of razors.

You told the panel that you did not know that the razors were there. You provided clear evidence that there was a defined place where razors were kept. You further stated that there was no reason for the razors to be in the lounge as they are not used there.

The panel determined that given that these razors were not visible, it was not unreasonable to deduce that you did not know that the razor was in the wooden cabinet in the lounge. On the balance of probabilities, the panel found that you did not know that they were there.

Accordingly, the panel found Charge 7(iiii)(a) not proved.

The panel next considered Charge 7(iii)(b). It had regard to the photograph exhibited by Witness 2 of the armchair of a chair in the lounge.

You told the panel that there was an ongoing issue with a resident ripping the chairs. You said that new chairs had been ordered and you were waiting for the delivery.

The panel found your evidence that the chair had only been in the lounge momentarily to be unlikely. You knew that the chair was in the lounge of the Home and given that there was a breach in its material, this created a significant risk of harm for infection especially as this incident took place during COVID-19 pandemic. The panel found it was more likely than not that you permitted the chair to remain there whilst the Home awaited replacements.

Accordingly, Charge 7(iii)(b) is found proved.

The panel next considered Charge 7(iii)(c). The panel had sight of the photograph exhibited by Witness 2 which is of the fire exit which was blocked by a large piece of activity equipment. You told the panel that residents were taken outside on a daily basis. You stated that you did no checks around the Home after your suspension as Registered Manager on 13 November 2020 and that the photograph must have been taken after this date. However, Witness 2 gave evidence that the photographs were taken on her first day at the Home in early November 2020 when you were still the Registered Manager.

The panel therefore found that, as Registered Manager, you should have known that the fire exit shown in the photograph was blocked which would have caused risks in the event of an emergency evacuation.

Accordingly, the panel found Charge 7(iii)(c) proved.

The panel next considered Charge 7(iii)(d). It had sight of the photographic evidence from Witness 2 of a shattered window.

Having heard evidence that Residents go outside on a daily basis, the panel determined that the broken window posed a risk. It was partly boarded but only on one side and from its appearance, the panel found it had been broken for some time. If shards were to fall out, this could have injured residents, and therefore, you should have dealt with this to prevent a risk of harm.

Accordingly, the panel found Charge 7(iii)(d) proved.

The panel next considered Charge 7(iii)(e). The panel had sight of the photograph exhibited by Witness 2 which showed a number of items on a walkway next to a row of wheelie bins. Witness 2 stated in her oral evidence that these items were at the far side of the garden and on a fire escape route. During cross examination, it was put to Witness 2 that whilst unsightly, there appeared to be room to walk around the discarded items. Witness 2 responded, *"that's correct but irrelevant. You're not allowed to place combustible materials in a fire escape route".*

You told the panel that the items photographed were beyond a locked gate and not in the residents' area. You further explained that these items were discarded and waiting collection.

The panel found that, whilst these items were alongside a fire escape route, it was by Witness 2's admission during cross examination that the path was wide enough to be

walked around. As such, the panel found that there was a low risk of harm. It was satisfied that you permitted the items to be there but was also satisfied that you had arranged for the items to be collected and removed and accordingly that they did not represent a safety hazard.

Accordingly, the panel found Charge 7(iii)(e) not proved.

The panel next considered Charge 7(iiii)(f). It had regard to the photographic evidence exhibited by Witness 2 depicting a bag of milk powder. When this photograph was shown to Witness 2, they admitted that they had misread the date. The panel therefore found that the food was not expired.

Accordingly, the panel found Charge 7(iii)(f) not proved.

The panel next considered Charge 7(iii)(g) and had regard to the photographic evidence exhibited by Witness 2 of the locked fire escape gate. During your oral evidence, you told the panel that the keys to this gate were kept in the nurses' station.

The panel noted that the fire escape gate was locked by way of a padlock which would require a key to open. In the event of an emergency, there would have been a serious risk of harm given that the keys were kept away from this area. As such, the panel found that you permitted this hazard and therefore failed to maintain a safe environment.

Accordingly, the panel found Charge 7(iii)(g) proved.

The panel next considered Charge 7(iii)(h). It had regard to the photograph exhibited by Witness 2 which showed a computer with the password on top of the screen. You told the panel that only nurses use this computer.

The panel heard during oral evidence that this was the right password for the computer shown in the photograph. It was concerned that, whilst only nurses were intended to use

this computer, the password was visible and could easily be accessed by any other personnel in the office. The panel determined that this was inherently bad practice and is contrary to General Data Protection Regulation ("GDPR") and that you should have known this. Residents' data are at risk of harm as sensitive medical information are contained within the device. You admitted that some data relating to Residents' referrals were contained within this computer. As such, the panel determined that you did permit an unsafe environment.

Accordingly, the panel found Charge 7(iii)(h) proved.

The panel next considered Charge 7(iii)(i). Having found Charges 4(x)(a) and (b) proved, the panel noted that there was not an adequately stringent practice at the Home to maintain the safety of medications. The panel therefore found that you did permit such a practice of allowing the cubicle, which kept the medication trolley, unlocked and that this constituted an unsafe environment.

Accordingly, the panel found Charge 7(iii)(i) proved.

The panel next considered Charge 7(iii)(j). The panel heard from Witness 2 that Resident S did not have a call bell installed in their room. It was Witness 2's evidence that this caused a risk of harm in the event an emergency arose and urgent help was needed. Witness 2 stated that she had discussed this issue with you and you had explained that you deemed that it was unsafe for Resident S to have a call bell as they had made a previous suicide attempt and the care plans stated they were at a high risk of suicide.

You told the panel that you assessed Resident S and had decided against installing a call bell because of the exposed cord may create a suicide risk. You made alternative arrangements and installed a sensor mat; in addition, all residents had a call bell that was attached to the wall.

The panel determined that there appeared to be a pattern of a difference in professional opinion between Witness 2 and you. The panel found that you had a good working knowledge of all of the residents and did not find that you had created an unsafe environment in not installing a corded call bell, taking into account the particular circumstances of Resident S. The panel found that you did create a safe environment by seeking an alternative arrangement for Resident S.

Accordingly, the panel found Charge 7(iii)(j) not proved.

The panel next considered Charge 7(iii)(k). The panel had sight of the photographic evidence exhibited by Witness 2 which shows a broken toilet roll holder which was situated above a grab bar. You told the panel that you were not aware that this was broken and would have instructed maintenance to fix this had you known.

The panel found that this was undisputed. The panel took the view that you should have known that the toilet roll holder was broken, as you had stated that you performed daily checks, or at least, staff members should have been aware of the process to request for this to be fixed. Staff members should have been aware that they had a duty to report issues, and how they could raise such matters. Therefore, the panel found that you did permit this hazard to be present.

Accordingly, the panel found Charge 7(iii)(k) proved.

The panel next considered Charge 7(iii)(l). The panel took into account the photograph provided by Witness 2. The panel noted that the apron dispenser was reasonably installed in the resident's bathroom area to assist staff when conducting personal care.

Whilst the panel found that the hanging straps presented a low risk, it considered that the equipment is a part of daily life in a non-secure care home such as St Augustine's. Therefore, the panel did not consider this as you permitting hazards in the Home.

Accordingly, the panel found Charge 7(iiii)(l) not proved.

Lastly, the panel considered Charge 7(iiii)(m). The panel had regard to the photographic evidence exhibited by Witness 2. The panel noted that the bag of sugar was sealed by a single plastic knot.

The panel considered that it would have been ideal to have such products in a container. Whilst the panel could not see the rest of the packaging and where exactly this was stored, it was not satisfied that the NMC has discharged the evidentiary burden to show sufficient evidence that this presented an unsafe environment.

Accordingly, the panel found Charge 7(iii)(m) not proved.

Charges 8(i) and (ii)

8. Failed to provide adequate care of residents' hygiene and/or well being in that:
    (i) On the 15th October 2020, resident H was left in urine-soiled clothes and an uncleaned room.
    (ii) On or about the 15th October 2020, Resident H was found to be wearing clothing belonging to numerous other residents.

Charge 8(i) and (ii) is found NOT proved.

The panel considered the stem of the charge. The panel found that you, as the Registered Home Manager, had a duty to provide adequate care of residents' hygiene and/or wellbeing.

In considering Charge 8(i), the panel considered the evidence of Witness 4. In their statement to the NMC dated 28 January 2022:

‘15. Resident H also had soiled clothes on, you could smell urine from him and it was generally not good practise to see a resident like this. It is possible Resident H’s room had not been cleaned yet by housekeeping and he had not received personal care, although he was dressed. There was no long term harm to Resident H from this but it placed him at risk of UTIs and bacterial infections which could have led to hospitalisation.’

In your oral evidence, you told the panel that you also found Resident H in this state. You instructed staff to clean Resident H. However, when staff attempted to give personal care to Resident H, he became aggressive and required Lorazepam to calm him down. Therefore, you asked the staff to let him rest until he was sufficiently calm for personal care to be safely carried out.

The panel found your evidence to be convincing and that it represented a logical course of action given the circumstances and provided for Resident H’s wellbeing.

Accordingly, the panel found Charge 8(i) not proved.

In relation to Charge 8(ii), the panel had regard to Witness 4’s statement to the NMC dated 28 January 2022:

’14. Resident H had urine-soaked slippers and socks on him that were labelled for other service users.’

You told the panel that it was possible that Resident H was wearing another resident’s clothing.

The panel heard evidence that there was a system in place to label residents’ clothes. However, notwithstanding, the panel took the view that residents may have had their clothing mixed with another resident from time to time, particularly in a multioccupancy setting such as this Home. The panel was not satisfied that this

resulted in stress to Resident H or represented a failure on your part to provide adequate care.

Accordingly, the panel found Charge 8(ii) not proved.

Charge 8(iii)

8. Failed to provide adequate care of residents' hygiene and/or well being in that:

   (iii) Left Resident E in a urine soaked room with a malodorous, dirty penis with accumulated skin cells whilst dressed in dirty pyjamas and only dirty linen for his bed

Charge 8(iii) is found proved.

The panel considered the stem of the charge. The panel found that you, as the Registered Home Manager, had a duty to provide adequate care of residents' hygiene and/or wellbeing, went onto consider whether you failed to provide this as outlined in Charge 8(iii).

The panel noted Witness 4's statement to the NMC dated 28 January 2022:

'35. Resident E's penis smelt highly malodorous but this seemed more from poor hygiene rather than strong urine associated with any infection. The urine in the leg was a normal yellow colour and consistency. I had no concerns that Resident E had a urinary tract infection (UTI) as there was no indication of this. The leg bag was stained with urine which looked in my opinion to be associated with not being changed regularly or Resident E not drinking enough fluids causing the concentrated build up.

[…]

38. […] *Overall, Resident E's personal hygiene seemed very poor. Resident E's room had a strong smell of urine. Resident E's penis was dirty with build-up of skin cells around the end of his penis, it was highly malodourous and his pyjamas were dirty. Resident E's bed linen had been stripped. Resident 's pillow and duvet had dried blood on them but generally the duvet and pillow were very dirty. I asked if they had come from Resident E's home, to which he said no. I would have expected better laundering facilities by the Home and I was generally appalled that they had not been replaced. I visually inspected for any injuries or wounds but there was nothing to note. Possible nose bleed as some spotting of blood noted to the pillowcase, Resident states he gets these from time-to-time. Head-to-toe check, all areas intact and free of injury.'*

You told the panel that you left Resident E because he was sleeping. You accepted that the room was dirty and that Resident E's condition was poor at that time. You could not say how long Resident E had been in that condition. You told the panel that once this was brought to your attention, you instructed that a deep clean was carried out and personal care was given to Resident E and that the CQC saw him prior to this being carried out.

The panel noted that the visit from Witness 4 took place around 10:30. You did not dispute that this was the state that Resident E was found in. Given that there was no dispute in the state that Resident E was found in, the panel therefore found that more likely than not that this was the state in which Resident E had been in prior to Witness 4's visit and therefore, as the Home Manager, you failed to provide adequate care of the Resident's hygiene.

Accordingly, the panel found Charge 8(iii) proved.

Charges 8(iv)

8. Failed to provide adequate care of residents' hygiene and/or well being in that:
   (iv) Permitted residents to not wear socks or shoes.

Charge 8(iv) is found NOT proved.

The panel noted that the evidence for this charge came from Witness 2. You accepted in your evidence that it was highly likely that residents were not wearing shoes or socks. However, you said:

> *"sometimes with extreme challenging behaviour,* [residents] *removed shoes or socks. Usually, I encourage them to wear. Can't force them. Just encourage"*

The panel noted that this was a Home which had some residents with complex cognitive abilities and extremely challenging behaviours. The panel accepted that given the nature of the residents that it was likely that there would have been residents who may not have been compliant with an instruction to wear shoes and socks. It did not therefore accept that this comprised failure to provide adequate care of residents' hygiene or wellbeing.

Accordingly, the panel found Charge 8(iv) not proved.

Charge 9

9. On the 25th October 2020, when Resident H fitted whilst you were on duty and he was in your care, you failed to seek a medical review for him.

Charge 9 is found NOT proved.

The noted that this charge is a duplicate of Charge 4(iii). Having found Charge 4(iii) not proved, the panel found that it would be contradictory to find Charge 9 proved. Furthermore, having considered the evidence as mentioned in Charge 4(iii), the panel noted that you made professional clinical observations and noted in the clinical notes that Resident H did not have a fit but had instructed other staff members to monitor him as a precaution. No other clinical incidents involving a fit took place, and therefore, based on your professional opinion, there was no need for a medical review on that date.

Accordingly, Charge 9 is found not proved.

Charge 10

10. On the 2nd November 2020 failed to provide any assistance or support to your staff when Resident H fitted again.

Charge 10 is found NOT proved.

The noted that this charge is duplicate of Charge 4(i). Having found Charge 4(i) not proved and its findings in Charge 9, the panel found that it would be contradictory to find Charge 10 proved.

Accordingly, the panel found Charge 10 not proved.

Charge 11

11. Subsequently when asked by BKR Consultant 1 whether you had been on duty when Resident H fitted on an occasion prior to the 2nd November 2020, you inaccurately stated you had not.

Charge 11 is found NOT proved.

The panel considered the evidence as outlined in Charges 4(i), (ii) and (iii). Having found that it was your professional clinical opinion that Resident H did not have a fit on 2 November 2020, the panel was not satisfied that this charge is found proved.

Accordingly, the panel found Charge 11 not proved.

Charge 12(a) and (b)

12. Your answer at 11 was dishonest in that
    (a) You knew you had been on duty at a previous fit on the 25th October 2020
    (b) You had recorded that fit in the notes.

Charge 12(a) and (b) are found NOT proved.

The panel bore in mind the case *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club)* [2017] UKSC 67. The panel noted that it must take a two-stage approach:

1) What was the Registrant's actual state of knowledge or belief as to the facts, and
2) Whether, in the light of this, the conduct was dishonest by the standards of ordinary decent people.

The panel first considered whether Resident H had a fit on 25 October 2020. The panel reviewed the evidence as outlined when considering Charges 4(i), (ii) and (iii). Having found that in your professional clinical opinion, Resident H did not have a fit on 25 October 2020, you had detailed this occurrence in his clinical notes. The panel was therefore satisfied that you had not been dishonest.

Accordingly, the panel found Charge 12(a) and (b) not proved.

Charge 13

13. Failed to update your own clinical knowledge beyond mandatory in-service training by reference to additional reading and attendance at forums.

Charge 13 is found NOT proved.

The panel noted that the evidence for this charge is Witness 2's conversation with you. The panel had regard to Witness 2's statement to the NMC dated 24 May 2022:

> *'66.Around the 11th of November I spoke to Giorgiana to try and build rapport. I asked how Giorgiana built on her clinical knowledge, she did not understand and so I asked did she read the Nursing times, journals attend CPD course etc. Giorgiana said to me, she didn't update her nursing knowledge*.[…]'

You told the panel that you found Witness 2's questions *"silly"* as you misinterpreted this to the question as to how you updated yourself when at work. You were confused as to why Witness 2 would ask you questions about clinical updating at work. You told the panel that you were too busy at the time and Witness 2's question was unexpected. You explained in your oral evidence you attended mandatory training and training events. You also said that you received and read email updates related to nursing, as well as reading newsletters.

The panel heard evidence from Dr 1 in which he described you as *"conscientious"* and *"gave the impression that* [your] *clinical knowledge is up to date".*

In considering the above evidence, the panel was satisfied that you demonstrated good insight into knowing whether the residents in your care needed medical input. You knew your patients well and were described as being caring towards them. The panel saw photographic evidence of you attending a healthcare conference. The panel found that on the balance of probabilities, it was more likely than not that you were conscientious in keeping your clinical knowledge updated and that you had misunderstood Witness 2's question.

Accordingly, the panel found Charge 13 not proved.

Charge 14

14. In all or any of the above, failed to provide sufficient and/or adequate leadership for the Home.

Charge 14 is found proved.

In reaching this decision, the panel took into account the oral evidence of the CQC inspectors, Witnesses 1, 3 and 6 that as a Registered Home Manager, you had a legal responsibility to manage and lead the Home.

The panel noted that as the director and owner of the Home, Owner 1 was controlling. It heard evidence from you that you felt unable to make decisions which involved the day-to-day running of the Home. As such, the panel found that this impeded significantly on your ability to assert yourself as the leader and make independent decisions to manage the Home without constantly referring to Owner 1.You told the panel that in hindsight, you should have reported your difficulties with Owner 1. However, the panel determined that as the legally responsible person for the Home, you would have known that you had a duty to protect the residents and your staff members, and as such, having had the obstacle of a controlling owner, you should have sought the assistance of external bodies but did not. This resulted in the Home not being well led.

Accordingly, the panel found Charge 14 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

You gave evidence under affirmation.

Mr Edenborough on behalf of the NMC, invited the panel to take the view that the facts found proved amount to misconduct. Mr Edenborough referred the panel to sections within *'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)'* ("the Code").

Mr Edenborough submitted that each of the charges found proved amount to misconduct, and there was a pattern over the period of time covered by the charges of similar failings.

Mr Edenborough identified the specific, relevant standards where your actions amounted to misconduct. This included sections 1, 1.1, 1.2 and 1.4. He submitted that most of those are engaged because of the management failures which resulted in people not being treated with kindness, respect and compassion. He submitted that sections 2 and 2.6 are relevant because of your failure to respond to residents who were crying out in distress.

Mr Edenborough further submitted that sections 4 and 4.7 has been breached given that there is a degree of record keeping issues in which you directly failed to practise in line with the best available evidence. He submitted that proper assessments of residents were not carried out, and there was a failure to demonstrate up-to-date knowledge of practice. There are instances in your case in which work was either not carried out properly or there had not been sufficient oversight.

In respect of sections 9 and 9.4, Mr Edenborough submitted that, in line with the broad theme of management failure, the lack of training available to staff members was contrary to these sections of the Code.

In relation to 13, 13.5 and 19, Mr Edenborough submitted that these standards within the Code might apply here in two ways. Firstly, you went beyond your competence in terms of management ability by accepting a role and persisting in it. Secondly, you had difficulties in areas such as catheters and training for others, as well calculating staff numbers and not being properly trained to do so but you continued to persist in the role regardless of the risks.

Mr Edenborough submitted that sections 16, 16.1, 16.2, 16.3 and 16.4 are also relevant in respect of failures to escalate matters including structural matters such as staffing levels. He acknowledged that the difficulties that the panel heard in evidence is in relation to Owner 1, who you may have found challenging and therefore the reason why that escalation did not take place.

In relation to 17 and 17.1, Mr Edenborough maintained that your failure to respond to residents in distress amounted to misconduct.

Furthermore, having found charges relating to the unsafe storage of medical items, Mr Edenborough submitted that this would be in breach of section 18.4, as there is a risk from the unsafe storage of medication in terms of access.

Mr Edenborough further submitted that sections 20, 20.1, 20.3 and 20.8 of the Code had been breached. He reminded the panel that there were a number of photographs exhibited which demonstrated the considerable extent to which a risk of harm arose in a number of ways. He submitted that a very large number of things went wrong, and that undermines professionalism and trust and that these failings affect not only the wider profession's reputation but also amount to a failure of leadership at the time.

Finally, Mr Edenborough submitted that section 25 of the Code has been breached due to your lack of leadership and encapsulates a central failing in this case.

Mr Edenborough invited the panel to consider the NMC Guidance on misconduct (FTP-2A) recently updated on 6 May 2025. He outlined the relevant factors for the panel to consider. He submitted that you were acting in the course of your professional practice. He also submitted that there was a neglect of residents which he accepted was not intentional. However, as a result of the broader failings in your case which can be treated as particularly serious, there was a risk of harm which resulted in poor treatment with some of the risk actualising. Mr Edenborough invited the panel to consider the level of seriousness of those failings when deciding on whether your actions amounted to misconduct.

Mr Buxton conceded that some residents were exposed to risk of harm. However, he invited the panel to contextualise matters. He submitted that the charges found proved occurred over five years ago. He said that in that time you have learned lessons about yourself and nursing.

Mr Buxton submitted that there was no deliberate act or failing here that might have led to harm. He submitted that it is clear that you did your very best, and that position was supported by the NMC witnesses.

Mr Buxton submitted that whilst the influence of Owner 1 provided a challenge, he acknowledged that you also had a responsibility and should have stood up to Owner 1 and acted in accordance with your legal responsibilities as registered manager. However, Mr Buxton asked the panel to bear in mind your inexperience against Owner 1's controlling behaviour. He asked the panel to have regard to your explanation during your oral evidence as to why you did not go against Owner 1. You said that you were scared of him. At the time you were acting as the Registered Manager, you were [PRIVATE] and were told that you would be given full support. That support was lacking but despite this, you tried your best.

Mr Buxton reminded the panel of Dr 1's evidence. Mr Buxton submitted that Dr 1 was effusive in his praise of you and described you as *"responsible"* and *"raising matters appropriately".*

In respect of your inaction, Mr Buxton informed the panel that he accepted that there were certain instances in which your actions were inefficient (such as in terms of the care planning and the PEEPs documentation). He submitted that certain processes may not have been as stringent as one would expect and attributed this to your inexperience.

Furthermore, Mr Buxton submitted that you acted in a manner that you believed to be appropriate. However, through no fault of your own, this resulted in ineffective outcomes.

Mr Buxton outlined your response in respect of the admitted charges. In terms of the charge relating to amending the diary entry, you understood precisely what the situation was here and you made the amendment within the diary for all the right reasons.

In respect of the admitted charge relating to the mismanagement of night staff who were involved in an incident. He said that it is not clear what happened, but you recognised that you should have acted differently. However, that does not in itself diminish insight or an understanding of what has happened.

Submissions on impairment

Mr Edenborough moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Edenborough addressed each of the charges found proved and outlined in detail the seriousness and the risk of harm involved in those charges.

In addressing insight, Mr Edenborough submitted that given the risk of harm and your oral evidence, your insight has not fully developed yet. He questioned whether there were attitudinal concerns and whether this was a failing to deal with the issues more robustly because Owner 1 was particularly challenging to deal with. He questioned whether the failings were a personal responsibility issue or whether you looked to lean on Owner 1 rather than dealing with the issues yourself.

Mr Edenborough submitted that he recognised that you are a professional nurse who has acknowledged that you now need to look for appropriate support from others. He noted the number of positive references, and documents showing further training. However, he questioned whether the panel needed to see more before you are allowed to go back to an unrestricted nursing role.

Mr Edenborough submitted that the insight that you have provided is about improvements. In practice, the panel may be of the view that your insight has not shown what the risk was and referred to the effect of placing a resident (considered to be a high level of risk) in the

Home. He submitted that the risk appeared to have actualised on occasions as set out in some of the charges.

Mr Edenborough submitted that there is still a degree of risk of harm going forward because those aspects of insight into risks are not fully developed. In looking at the individual charges, there is a varying degree of seriousness, and therefore, he submitted that you are impaired based on the grounds of public protection and also the wider public interest.

Mr Buxton submitted that he disagreed that there was a pattern of behaviour in your case. To consider that there had been a pattern of behaviour without specifying why runs the risk of leading one to the erroneous view that there was some attitudinal concern or failing here which gave rise to those omissions. He submitted that it has never been the case of the NMC that any of the events in this case were deliberate and attitudinal.

Mr Buxton submitted that since the end of 2020, you have worked without incident and with general approbation and praise of colleagues and managers alike. He submitted that you posed no risk and have not been found to demonstrate any failings or concerns that might lead one to believe that any risk is involved. You have practised under a condition that you do not act as a manager or deputy manager without issue.

Mr Buxton invited the panel to carefully consider your response bundle and drew the panel's attention to the relevant pages. He asked the panel to consider whether, in light of this, there was an appreciable risk of harm and that from a public protection point of view, whether in 2025, given what you have learned and expressed in terms of contrition, you have an understanding as to what happened and why it happened.

Mr Buxton submitted that you have been frank with your need for support. He said that this is the greatest indication of insight, and you have taken a responsible attitude to practice in the future with the principle of safe practice and consideration of risk.

Mr Buxton invited the panel to consider whether you are capable of kind, safe and professional practice. He submitted that there is no question that you have the correct attributes to be a nurse. You have sympathy, and are kind, caring and hard working. You have proved that you are capable of practising in such a manner since 2020.

In addressing the public interest, Mr Buxton submitted that this is a nuanced area when considering impairment. He reminded the panel that it has never been the case of the regulator to seek a finding of impairment to be punitive. Mr Buxton submitted that the charges found proved occurred back in 2020 and, whilst a number of charges were found proved, this does not in itself require a finding of impairment on public interest grounds.

Mr Buxton submitted that a fully informed member of the public with the understanding that this care home was being run as a business by Owner 1 explains some (although not all) of what happened. The circumstances had been an important learning experience for you but you tried your best. Mr Buxton submitted that a member of the public, apprised of the context, would not be concerned if no impairment was found because a long period of time has elapsed, during which time you have not worked as a manager but have displayed all of the attributes and characteristics of good nursing practice as shown by the evidence before the panel today.

Mr Buxton submitted that you have been able to articulate a clear understanding of what is required from a good manager of a home. You have learned from your experience that you were possibly out of your depth but there were many aspects of your managerial skills that were good, caring and responsible.

Mr Buxton informed the panel that he does not wish to detract or minimise the incidents that occurred, however, you have now demonstrated a full ability to practise as a nurse without restriction (and not in the capacity of a manager or deputy manager). You are a safe nurse, and the public requires a nurse, who in all other respect is hardworking and responsible, to be allowed to practise unrestricted in order to provide the vital service that

nurses do. Mr Buxton reminded the panel that, in your evidence, you had told the panel that you have no intention of seeking a managerial role for at least five years.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin), *Schodlok v General Medical Council* [2015] EWCA Civ 769, *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* 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.'* When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

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

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 Treat people with kindness, respect and compassion.*
> *1.2 Make sure you deliver the fundamentals of care effectively.*
> *1.4 Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*
>
> ***5 Respect people's right to privacy and confidentiality***

To achieve this, you must:

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

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 Maintain the knowledge and skills you need for safe and effective practice.

8 Work co-operatively

To achieve this, you must:

8.6 Share information to identify and reduce risk.

10 Keep clear and accurate records relevant to your practice

To achieve this, you must

10.5 Take all steps to make sure that records are kept securely.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.3 Ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.

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

To achieve this, you must:

16.1 Raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels

available to you in line with our guidance and your local working practices.

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

16.6 Protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised.

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

To achieve this, you must:

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

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

To achieve this, you must:

18.4 Take all steps to keep medicines stored securely.

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

To achieve this, you must:

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

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 breaches of the Code do not automatically result in a finding of misconduct. The panel comprehensively reviewed each of the charges found proved in your case and considered whether they constituted a breach of the Code and amount to misconduct.

Charges 1(i), 5(ii)(a), 5(ii)(b), 5(ii)(c) and 5(ii)(d)

The panel found that Resident A was left on a mattress lowered near to the floor which did not contain assistive technology or a crash mat. The reason for the low bed was that the resident was frail and frequently found at the edge of the bed. This was lowered to help avoid potential injury. As these risk factors were known, you should have been proactive in implementing appropriate technology. The delay in installing a crash mat and sensor meant there was a period in which Resident A was at greater risk of harm.

Whilst the panel has not seen evidence before it that you were the staff member who made the decision to lower Resident A's mattress on 14 October 2020, you had a duty, as the Registered Manager to ensure that risks were proactively mitigated through appropriate care plans. The panel accepted that lowering the bed was the appropriate

action but this in fact could have created further risks without the prior installation of a crash mat and sensor to ensure that Resident A was protected in the event of a fall.

In light of the above, the panel determined that sections 1.2 and 25.1 and 25.2 has been breached, and therefore your conduct amounted to serious misconduct due to the risk of harm presented to Resident A.

Charges 1(iv) and 1(v)

The panel considered that as the Registered Manager and Registered Nurse, you had a duty to be extremely alert to safeguarding. Bruises that were found on Residents G and H should have been a serious concern. You failed to make further enquiries that would safeguard not only the residents involved but also other residents by not sufficiently investigating the root cause of the concerns. In the case of Resident G, the panel found that you had failed in your duty to report potential maltreatment in a previous care setting to the Local Authority Safeguarding Team. This had the potential to put other vulnerable people at risk of harm.

The panel therefore found that your inaction amounted to serious misconduct and breached 16.1, 16.4 and 17.1 of the Code.

Charge 1(x)

The panel bore in mind the importance of the context surrounding this charge. From your oral evidence during the facts stage, you gave evidence that the choice of admission lay with Owner 1, and it was a starting point for you to accept all new residents. However, as the Registered Manager, you had a duty to ensure the safety of your residents and staff members. The panel heard evidence that Resident B had a history of problematic behaviours. The panel found that whilst inexperienced when you took the role of Registered Manager, you had been the manager for some time and would have been familiar with admission processes and should have been able to identify the issues that

came with the admission of Resident B into the Home. Without a risk assessment, you were unable to properly determine the resource needed to safely manage this resident.

The panel therefore found that this was a significant falling short of the standards expected of not just a competent registered nurse, but as a Registered Manager who had legal responsibility for the Home and its residents. The admission of Resident B required a more in-depth discussion and assessment as to the risk this resident posed to the staff, other residents and to himself. The panel determined that you breached sections 1.2, 17 and 17.1 of the Code.

Charges 2(i)(a), 2(i)(b) and 2(i)(c)

The panel noted that these charges were admitted from the outset of the proceedings. It heard oral evidence from you about what happened during the night in question. The panel therefore considered the order of events as follows:

There was an altercation during a nightshift where it was alleged that Colleague 4 (Staff Member 2) had attempted to strangle Colleague 3 (Staff Member 5). An hour later, Colleague 3 called you, and reported the incident. You asked Colleague 3 whether she wanted to go home, but she refused and stated that she wanted to finish her shift. Colleague 4 also remained on shift. You contacted Owner 1 who told you that there was nothing further to be done and that you did not need to go into the Home that night.

The panel noted that although you offered for the victim (Colleague 3) to go home, you failed in your ability as the leader because the aggressor (Colleague 4) was not asked to leave the premises immediately after displaying violent behaviour. You did not properly consider the risk presented to colleagues and residents if Colleague 4, who was reported to be acting aggressively, remained in the Home. This risk could have been mitigated by you sending Colelague 4 home and completing her shift yourself. Therefore, the panel determined that this was a serious breach of the Code. Particularly sections 19.1, 16.6

and 25.1 and 25.2. Your actions fell seriously short of the standards expected and therefore amount to serious misconduct.

Charges 3(iii) and 3(vi)

In considering whether your actions in these charges amount to misconduct, the panel considered you were unfamiliar with dependency tools and said you had never seen one before. By your own admissions during your oral evidence that there were gaps in your knowledge about dependency tools as you had never seen one before. The panel bore in mind that much of your knowledge regarding this area was from Owner 1, who closely monitored how the dependency tool was used and insisted that staffing levels were sufficient.

Owner 1 had not provided you with the training required to be in a management position. However, as a registered nurse, who was in a management position, you should have taken initiative to develop your own understanding of dependency tools and how they help inform staffing levels and skill mix. You should have identified where your knowledge and understanding fell short and taken steps to address these issues. You should have carried out your own research and learning to understand methodology in calculating safe staffing numbers.

The panel determined that your actions amounted to misconduct. The effect of your failure to fully understand the tool meant the effect of your failure to fully understand the tool meant there was an over reliance on a poor-quality dependency tool and staffing levels were calculated based on inaccurate assumptions. This created a significant risk of harm to residents given their vulnerabilities and the volatile nature of some of the residents in your care. The panel therefore found that this was in breach of sections 6, 6.2, 25.1 and 25.2 of the Code.

Charge 4(iv)(a) and 4(iv)(b)

Having found these charges proved in respect of Resident E, the panel considered the pain and distress that Resident E was experiencing. The panel noted that Resident E's shouting was normalised to such an extent that you had learned to ignore this. Resident E was a vulnerable resident and known to be suffering from a UTI (which was noted in his medical records), and as such you should have taken action to investigate his distress rather than leaving him in pain or discomfort longer than necessary.

In light of the above, the panel found that your actions fell short of the conduct expected of a nurse and as a Registered Manager and therefore, amounted to serious misconduct and a breach of the Code, specifically sections 1.1, 1.2 and 1.4.

Charge 4(vii)

The panel noted your admission that you had deleted the entry in the diary. The panel considered the purpose of the diary and as it has not seen any copies of the diary in question or the format it was in, it cannot determine whether the deletion of such an entry would have caused confusion or a risk of harm to the resident in question.

The panel determined that having seen entries in Resident E's nursing notes, the deletion of the diary entry did not cause Resident E any harm, as there was no need for Resident E to see a doctor at the time.

Therefore, the panel does not find your action in Charge 4(viii) constituted professional misconduct.

Charges 4(x)(a), 4(x)(b), 4(x)(c), 4(x)(k) and 7(iii)(i)

The panel considered each of these charges individually and noted that there had been a recurrent theme of habitual unsafe practice. As the manager, you had a duty to set the standards for safety and risk management. However, you failed to do that.

The panel therefore decided that your conduct in these charges amounted to serious misconduct, and a breach of the Codes, specifically, 10, 18, 18.4 and 25.2. These were not isolated failures but a representation of an ongoing lax approach in medication storage throughout the Home which, as Registered Home Manager, you were responsible for.

Charge 4(x)(f)

The panel considered its findings regarding this charge. The panel found that there was insufficient evidence before it to demonstrate serious misconduct. However, it noted that it was evidence of poor housekeeping which fell within your remit to check. However, it was not satisfied that this reached the threshold for misconduct.

The panel therefore did not find that your actions in Charge 4(x)(f) amounted to misconduct.

Charge 4(x)(i)

The panel recognised that there were times that a pragmatic approach is appropriate in that another staff member may need to approach a patient after they had refused medication from you. The panel considered your actions in this charge was more pragmatic as opposed to misconduct. It noted that you should have then obtained dual signatures on the MAR chart.

However, the panel did not find that your actions in Charge 4(x)(i) amounted to misconduct.

Charge 4(x)(l)

The panel considered the evidence provided during the facts stage. It noted that whilst, factually, it found that Resident J had medication crossed off without dates or signature, it could not be determined who might have been responsible for this, and whilst you should

have brought this to the attention of the prescriber, it was not satisfied that this reached the threshold of serious misconduct that you could be held responsible for.

The panel did not therefore find misconduct in respect of this charge.

Charge 4(x)(p)

The panel considered the importance of body maps which they determined would be used regularly in the Home. Having seen examples of body maps during the facts stage, the panel found them to be of poor quality and lacking in detail such that they could have affected future medical care for the relevant individual. As such, as the Registered Manager and a nursing professional, it fell within your remit to ensure that all staff members were competent in accurately completing body maps and for you to have ongoing oversight.

The panel therefore found that your conduct in Charge 4(x)(p) fell seriously short of the standards expected and therefore amounted to misconduct and a breach of section 25.2 of the Code.

Charges 5(i)(a), 5(i)(c) and 5(iii)

The panel noted that you had a duty to provide an appropriate and up-to-date catheter care plan. It was important that this was available to support colleagues in delivering the care that Resident E required. As a manager, you should have recognised that this was a fundamental skill that all staff members (including yourself) should possess. Whilst the panel recognised that much of the financial control rested with Owner 1, you had a duty to seek the relevant support to ensure that guidance was available in the Home and care plans were correct and sufficiently detailed, as the consequences of not doing so caused a risk of harm for Resident E and others who may need a catheter.

The panel decided to your conduct amounted to serious misconduct and in breach of sections 6.2, 13.3 and 25.2.

Charge 6(ii)

The panel determined that as the Registered Manager of the Home and a registered nurse, you had a general responsibility to ensure that your skills and that of your staff members were updated. It would not be unusual for staff members to receive training on catheters and considered this as part of the fundamental skills of a nurse, particularly in a care home such as St Augustine. Whilst Owner 1 had control of the finances, you had a duty to find accessible resources that you could use or explore assistance from external agencies when you felt that the skill set of the staff members did not meet the requirements of the residents and therefore posed a risk of harm to both staff and the residents.

The panel therefore decide that your actions amounted to misconduct and in breach of the Code, specifically, 6.2, 13.3 and 25.2.

Charge 7(ii)

In considering whether your actions amount to misconduct, the panel noted the PEEPs provided to Witness 6 which had been considered as inadequate because they did not contain individual detail concerning evacuation needs.

The panel therefore determined that you placed residents at risk of harm by failing to detail their personal needs in the event that an emergency evacuation was to take place. The panel found that your actions was a serious breach of sections 19.1 and 25.1 of the Code.

Charge 7(iii)(b)

The panel noted that it has not received any evidence to indicate how long the chair had been in the lounge for. Whilst it should have been removed quickly (given the heightened concerns regarding infection during COVID-19), it was not satisfied that this reached the threshold for misconduct.

The panel therefore did not find that your actions in this charge amounted to misconduct.

Charge 7(iii)(c) and 7(iii)(g)

The panel noted that it would have been extremely important to ensure that access to the fire exit was not blocked and that the path was accessible in the event of an evacuation. By not doing so, you failed to address the risk of harm to the residents at the Home and your staff members.

The panel determined that your actions were in breach of sections 19.1 and 25.1 of the Code and amounted to serious misconduct.

Charge 7(iii)(d)

The panel noted that leaving a shattered window uncovered on one side posed risks to staff members and residents who you stated during oral evidence would have access to the garden on a daily basis. The panel found that the shattered window appeared to have been broken for some time and if shards were to fall out, could have injured residents, and therefore, as Registered Home Manager, you should have dealt with this to prevent a risk of harm. By failing to do so, you placed vulnerable residents and staff members at risk of harm.

As such, the panel decided that your actions amounted to misconduct and a breach of sections 19.1 and 25.1 of the Code.

Charge 7(iii)(h)

The panel noted that as the Registered Manager, you had a responsibility to ensure that all data relating to residents at the Home was kept safe and adhered to GDPR. By leaving the password to the computer on display which appeared to have been there for some time, the medical data within the computer could have been accessed by anyone and therefore, your actions had the potential to breach privacy and/or cause harm to the residents. As a nurse in a leadership position, you should have been able to recognise the issues regarding this and addressed it.

Accordingly, the panel found that your conduct fell short of the standards expected of a registered nurse and therefore amounted to misconduct, and breaching sections 5.1 and 10.5 of the Code.

Charge 7(iii)(k)

The panel noted that the evidence for this charge was undisputed. When it considered the nature of the charge, the panel took the view that this did not reach the threshold to amount to misconduct.

Accordingly, the panel did not consider your actions in Charge 7(iii)(k) to amounted to misconduct.

Charge 8(iii)

Having found this charge proved, the panel considered the seriousness of your conduct. You accepted that Resident E's room was dirty, and that Resident E was in a poor condition at that time. The panel took the view that there was a failure to deliver fundamental care in a timely way. This amounted to serious misconduct.

Accordingly, the panel found that your actions fell short of the standards expected of a registered nurse and therefore amounted to misconduct and a breach of sections 1.1, 1.2, and 17.1 of the Code.

Charge 14

The panel had careful regard to your evidence that Owner 1 had been controlling and that you felt unable to make decisions which involved the day-to-day running of the Home. You recognise now that you should have sought assistance from external agencies, and had taken on a role that you were not ready to take. However, whether you were sufficiently experienced or not, you took the position and were therefore legally responsible. You should have taken steps to develop the necessary skills instead of relying on Owner 1. Whilst the panel was empathetic of your plight in that you did not receive the support and training that you needed from Owner 1, you should have taken the initiative to find other ways to develop your skills and obtain the help you needed to safeguard your residents and ensure that your staff members were competent.

Accordingly, the panel found that your conduct amounted to misconduct and breached sections 25.1 and 25.2 of the Code.

The panel found that your actions in Charges 1(i), 5(ii)(a), 5(ii)(b), 5(ii)(c), 5(ii)(d), 1(x), 2(i)(a), 2(i)(b), 2(i)(c), 3(iii), 3(vi), 4(iv)(a), 4(iv)(b), 4(x)(a), 4(x)(b), 4(x)(k), 7(iii)(i), 4(x)(p), 5(i)(a), 5(i)(c), 5(iii), 6(ii), 7(ii), 7(iii)(c), 7(iii)(g), 7(iii)(d), 7(iii)(h), 8(iii), and 14 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

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

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

d) […]*'*

In considering *Grant*, the panel found limbs a), b) and c) engaged in respect of the past. The panel found that patients were placed at risk of harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel next considered the latter part of the limbs. It bore in mind that impairment is a forward-looking exercise, and it next considered whether you are liable in the future to put patients at unwarranted risk of harm, bring the nursing profession into disrepute and breach one of the fundamental tenets of the nursing profession pursuant to *Grant*.

The panel determined that you had taken on a role that was beyond your skill level and the failings emerged from your failings as a manager rather than your failings as a nurse. The panel found that you possessed the core attributes of a nurse in that you seek to practise kindly, safely and professionally at all times. However, your lack of assertiveness in dealing with an overbearing owner contributed to poor management practice. It was this combined with a lack of training or support in your first management role that put residents at risk rather than your core nursing skills. The panel did not find attitudinal concerns as it found you to be candid and open about the failings and that any pattern of failings

stemmed from your limitations as a manager. Therefore, if you were to work as a nurse in the future, the panel did not find that limbs a), b), and c) would be engaged.

The panel bore in mind that it was tasked with considering your suitability to work as a registered nurse and not as a registered manager. It recognised that companies have their own measures and processes in place to establish your suitability to obtain a managerial role in the future and it is not for this panel to consider. The panel accepted that you have said that you are not seeking a managerial role in a healthcare setting within the next five years and your wish to pursue relevant training and studies to develop your knowledge and skills before embarking on a future managerial role. The panel therefore focused its consideration on your current ability to practise safely, kindly and professionally as a registered nurse.

In reaching its decision, the panel had regard to the principles derived from *Cohen* namely:

- Whether the concern is easily remediable;
- Whether it has in fact been remedied; and
- Whether it is highly unlikely to be repeated.

Regarding insight, the panel considered that the matters before it is easily remediable if it found that you had demonstrated insight. The panel noted that during the course of your oral evidence at this hearing, you were able to demonstrate a good understanding of your part in the failings of the Home. It considered your acceptance that you had been inexperienced when you took on the role and had been promised support by Owner 1 which did not materialise. You showed remorse for your omissions and explained how you would have handled the situation differently. You did not apportion blame for your ineffective leadership and have been frank and candid about what had gone wrong. The panel was satisfied that this was indicative of actual learning and was satisfied that you have sufficient insight into your failings.

The panel also considered whether your misconduct has been remedied. It heard evidence that you have been subject to an interim conditions of practice order with the sole condition of not taking on managerial roles. You have continued to work full time as a registered nurse at a nursing home without any difficulties arising and the recent testimonials from your line manager shows no concerns raised about your practice. You are compliant with mandatory training and explained that you are currently in the process of completing your National Vocational Qualification ("NVQ") Level 5 to demonstrate your competence in leadership and management skills.

The panel further heard oral evidence from you in which you gave an example in relation to medication storage and were able to identify good practice at your new employment. You were able to draw comparison to your previous experience at the Home and objectively explained how poor the systems had been. You gave evidence that you could and would seek assistance from external bodies if necessary and not to simply accept the opinions of people within the organisation.

The panel took the view that, in considering your current nursing practice, your recent testimonials from your line manager, and training compliance, your previous conduct at a nursing level is highly unlikely to be repeated. The panel therefore decided that a finding of impairment is not necessary on the grounds of public protection.

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

The panel acknowledged that there is a high bar in a finding of impairment on public interest grounds only. However, as this was a matter where there were numerous and significant failings in a care setting due to your misconduct, it determined that the public confidence in the profession would be undermined if a finding of impairment were not

made in this case given the volume and nature of the charges found proved in your case. There is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Therefore, a finding of impairment is necessary to maintain public confidence in the professions and the NMC as regulator.

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

Sanction

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

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

Submissions on sanction

Mr Edenborough submitted that the appropriate sanction in this case is a suspension order for nine months, and that a review is not necessary on the basis of the panel's finding that you are impaired only in the public interest. He noted the panel's decision that there is no attitudinal concern, and the matter simply needs to be marked.

Mr Edenborough referred the panel to the NMC Guidance. He submitted that there is a need to reflect the serious, significant and numerous failings that the panel has found in this case.

Mr Edenborough submitted that you have demonstrated, during the course of these proceedings, insight and remediation and bearing in mind the guidance, a caution order is only appropriate if there is no risk to the public or to patients that requires a nurse's practice to be restricted. He submitted unless the impairment is at the lower end of the spectrum, it may be argued that a caution order does serve to mark the seriousness of the case. He reminded the panel that it found numerous and significant failings in a care setting, and because of that, even a lengthy caution order would be insufficient to reflect those findings which include a significant risk of harm to a number of residents which perhaps that makes it more serious.

Mr Edenborough submitted that a conditions of practice order is not relevant because there are no practical conditions that would address the matters identified in this case.

Mr Edenborough submitted that a suspension order would address the level of seriousness and the misconduct in your case is serious given the consequences that flowed from it. However, he submitted that he recognised that it is not at all a case of multiple instances of deliberate neglect and there are some matters where there was inaction in respect of direct care rather than neglect.

Mr Edenborough acknowledged that you have previously had a good fitness to practise history, and you have practised recently without issue as a nurse. You have insight and understanding and there are no harmful or deep-seated personality or attitudinal issues found in your case. There is no evidence of repetition since the incident. He submitted that a caution order would not reflect the overall level of seriousness given the nature of the concerns which were widespread.

Mr Edenborough submitted that a suspension order for nine months would be sufficient to mark the seriousness of the charges.

The panel also bore in mind Mr Buxton's submissions. He submitted that a suspension order at this stage, in light of the panel's clear and fair determination on impairment, would be wrong and disproportionate. He submitted that the panel has indicated that you posed no risk to the public or service users as a registered nurse, and the panel has not found current impairment for public protection reasons. He reminded the panel that the impairment found was in the public interest only.

Mr Buxton referred to Mr Edenborough's submissions in which Mr Edenborough indicated that, if the panel were to impose a suspension order for nine months, no review would be necessary. Mr Buxton submitted that this is a public interest impairment case which effectively requires the panel to mark or send a message in declaring and upholding standards and confidence in the profession. He submitted that there is no current risk to

any service users, and whilst of course, the overarching principle of public protection does include the element of declaring and upholding standards, there is a need to be realistic about what has happened in this case and how things have changed.

Mr Buxton submitted that you have been frank, fully understanding, and recognised the reasons and matters that the panel set out within the determination. He submitted that this was demonstrated by your candour and openness with which you addressed the panel.

Mr Buxton submitted that you have already demonstrated sufficient insight in this case and these factors indicate why a sanction at the lower end of severity and restriction is appropriate.

Mr Buxton noted the NMC Guidance on '*Sanction'* (SAN-2). He acknowledged that the Home was not well led, which you fully accepted. Whilst it is understandable that cases involving abuse or neglect of vulnerable people is always serious, he respectfully submitted that it has never been said that you deliberately acted in a way which was intended to cause any harm at all. He submitted that given the panel's findings, you have demonstrated this to be a point in your career when you were relatively new and inexperienced as a manager. However, you did not fail and have not failed since as a nurse.

Mr Buxton submitted that the impact on public confidence has diminished. You have demonstrated a clear ability to practise kindly, safely and professionally, and the panel has identified that there is currently no risk to the safety of those who use the services under your care.

Mr Buxton invited the panel to consider proportionality. He submitted that in looking at the reasons, and the nature of the panel's findings of impairment, there are no aggravating features in your case. There has been no regulatory history, or concerns expressed about your nursing practice. There has been no abuse of position of trust and appropriate and sufficient insight has been found.

In addressing the mitigating features, Mr Buxton submitted that the panel has found impairment on public interest grounds alone, and that tempers the degree of restriction that is proportionate and required in this case.

In line with the NMC Guidance, Mr Buxton submitted that the panel must consider the following:

- Your clear evidence of insight. You acknowledged and understood the problem and have given a heartfelt apology for what happened and demonstrated full contrition. You also made efforts to prevent any repetition of this and that includes your commitment to achieving your level 5 NVQ qualification, which is to your credit.
- You have demonstrated the principles of good practice, and your work and training record demonstrates this. You have followed the terms of your interim order and acknowledge your testimonials.
- Personal mitigation. Mr Buxton invited the panel to consider your level of experience at the time, together with the lack of support that was given at the relevant time.

Mr Buxton submitted that any sanction would have an impact on a nurse's practice. A suspension would have devastating reputational and financial implications for you. You would lose your job at the nursing home where you have worked for a reasonable number of years and [PRIVATE].

Mr Buxton submitted that a caution order marks the seriousness of the misconduct and remains on your record for the duration. He submitted that it serves as an indication to anyone who enquires about your nursing PIN. Mr Buxton quoted the NMC Guidance on *'Caution Orders'* (SAN-3b). He submitted that your case falls fully within that order. He reminded the panel that there are no concerns about public safety. In balancing the interests of the public against the registrant, he submitted that this is a case where proportionality requires a fair and equitable outcome in terms of both the requirements of

the NMC as a regulator but also the requirement to allow a perfectly competent nurse to work without restriction.

Mr Buxton submitted that the charges found proved were from several years ago. He submitted that the public would not be concerned if the panel were minded to impose a caution order as an adequate sanction. He submitted that a suspension order for nine months would be disproportionate and unduly punitive.

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

Decision and reasons on sanction

Having found your fitness to practise currently impaired on public interest grounds only, the panel went on to consider what sanction, if any, it should impose in this case. The panel carefully considered its finding that your practice is not impaired on public protection grounds. It noted that there is a distinction between your practice as a Registered Manager for the Home and as a nurse. In considering the appropriate sanction, the panel bore in mind that it is marking the seriousness of the misconduct found proved when you were working as a manager, the impact on patients and their families and the reputation of the nursing profession and not your ability to practise safely, kindly and professionally as a nurse.

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 had regard to the NMC Guidance on *'Sanctions for particularly serious cases'* (SAN-2), and the section:

'When considering sanctions in cases involving the abuse or neglect of children or vulnerable adults, panels will, as always, start by considering the least severe sanction first and move upwards until they find the appropriate outcome. However, as these behaviours can have a particularly severe impact on public confidence, a professional's ability to uphold the standards and values set out in the Code, and the safety of those who use services, any nurse, midwife or nursing associate who is found to have behaved in this way will be at risk of being removed from the register.'

The panel took the view that the above section is relevant, not because it has found evidence of neglect but because there was a real potential for harm in respect of the residents in your care.

The panel carefully considered the circumstances of this case. The setting was a home where a number of residents had highly complex and severe conditions making them particularly vulnerable.

The panel also considered that whilst 34 wide-ranging charges were found proved, you were originally charged with 87 different elements of which 53 were found not proved and of those found proved not all were found to have amounted to misconduct. You were the Registered Manager with significant legal responsibilities but you did not stand up to Owner 1 even though you came to realise that his actions were often driven by financial interest and were not in the best interests of the residents.

The panel also took into account that whilst the panel has not heard from Owner 1, all witnesses consistently confirmed his controlling nature and it also noted after he had taken ownership of the Home there had been a notable turnover of Home Managers.

The panel considered that this was your first management role, and it was in a home with extremely complex and challenging residents. There had been no robust process when you were appointed as manager. You did not apply for the role rather you were simply promoted by Owner 1 after the previous manager had left and Owner 1 had taken

advantage of your placid nature and desire to please in selecting you to be the Registered Manager. This was done without proper assessment of your capability and experience. When you expressed reservations about taking on the role, Owner 1 insisted that he would provide full support and training, but this did not materialise.

After you were appointed as manager of the Home, your role became increasingly challenging because Owner 1 agreed to admit significant numbers of residents with extremely challenging behaviours that other care homes had been unable to manage. Owner 1 agreed to accept them without increasing staffing levels proportionately.

The panel found that you have shown insight and learning and have shown contrition and genuine remorse.

The panel also reminded itself that this stage of the fitness to practise process is a balancing act and there will always be a strong public interest in allowing a fully trained professional who has dealt properly with her past mistakes to continue to practise.

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.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 noted that you have shown insight into your conduct. You have apologised to this panel for your misconduct and showed evidence of genuine remorse. You have

engaged with the NMC since your referral and demonstrated that you have a sufficient understanding of your part in the failures identified in your case.

The panel determined that given the particular facts in your case a caution order would be appropriate. A long caution order would not diminish the seriousness of the findings and would be proportionate. The panel determined that the longest period for a caution order of five years should be imposed because it would mark not only the importance of maintaining public confidence in the profession but also send the public and the profession a clear message about the standards required of a registered nurse.

The panel determined that a conditions of practice order would not be appropriate or proportionate given the nature of the charges found proved. The panel has not identified any public protection issues in your case which would warrant a consideration for a conditions of practice order. The panel noted that no useful purpose would be served by a conditions of practice order.

In line with the legal advice and the submissions of Mr Edenborough and Mr Buxton, the panel also considered whether it would be proportionate to impose a more restrictive sanction by way of a suspension order. It carefully considered the submissions of Mr Edenborough in relation to the sanction that the NMC was seeking in this case and the NMC Guidance on *'Suspension Order'* (SAN-3d):

> *'Key things to weigh up before imposing this order include:*
>
> - *whether the seriousness of the case requires temporary removal from the register?*
> - *will a period of suspension be sufficient to protect patients, public confidence in nurses, midwives or nursing associates, or professional standards?*
>
> *Use the checklist below as a guide to help decide whether it's appropriate or not. This list is not exhaustive:*

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

[…]

When considering how serious the professional's conduct is, the Fitness to Practise Committee will look at how far the nurse, midwife or nursing associate fell short of the standards expected of them. It will consider the risks to patients and to the other factors above, and any other particular factors it considers relevant on each case.'

The panel determined that given it found you impaired solely on the grounds of public interest whilst you were working in the role of a manager, and that there had been no previous or subsequent concerns about your practice as a registered nurse, a temporary removal from the register would mark the public interest, but the panel went onto consider its proportionality in light of the contextual background of this case and whether it would be unduly punitive or serve the public interest. The charges found proved occurred during a period when you were unexpectedly promoted to Registered Manager. You were given this role despite not applying for it. You did not have the experience or the appropriate level of support and you operated in this role under the constraints of Owner 1.

At the time of these allegations, you had been in post for more than a year. The panel noted that a CQC review from September 2020 (dated 22 October 2020) had reported on the Home with many positive comments, including *'sufficient staff were available to provide safe care to people'* and *'Medicines were administered and managed safely'* and this report had been shared with you.

When the panel considered your conduct as a nurse rather than as a manager, the panel found that you have shown that you are able to practise kindly, safely, professionally and competently in a nursing role. The panel determined that whilst a suspension order for nine months would mark the public interest and importance of maintaining public confidence in the profession, it would not serve the public interest as it would remove an otherwise competent nurse from practice.

The panel therefore determined that a long caution order does not diminish the seriousness of the findings and would be appropriate in your case. For the next five years, your employer - or any prospective employer - will be on notice that your fitness to practise had been found to be impaired and that your practice is subject to this sanction. Having considered the general principles and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of five years would be the most appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession but also send the public and the profession a clear message about the standards required of a registered nurse.

In reaching this conclusion, the panel took into account that, in addition to a caution order for the maximum period, it has also marked the seriousness of your misconduct by a finding of impairment on public interest grounds. The panel also weighed in the balance the insight, remorse and remediation you have shown, the fact that you have practised as a registered nurse for the last five years without issue, the strong public interest in enabling a registered nurse with valuable skills and experience to continue in safe practice, and the likely financial and professional detriment that would result from a suspension order. The panel was confident that a well-informed, fair-minded member of the public would agree with this conclusion.

At the end of this period the note on your entry in the register will be removed. However, the NMC will keep a record of the panel’s finding that your fitness to practise had been found impaired. If the NMC receives a further allegation that your fitness to practise is

impaired, the record of this panel's finding and decision will be made available to any practice committee that considers the further allegation.

This decision will be confirmed to you in writing.

That concludes this determination.