Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Monday, 27 October 2025

Virtual Hearing

Name of Registrant:	**Mrs Keshwaree Ramana**
NMC PIN:	01I9597E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – 12 November 2004
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Graham Thomas Gardner (Chair, Lay member) Alison Bielby (Registrant member) Alison James (Lay member)
Legal Assessor:	Fiona Barnett
Hearings Coordinator:	Dennis Kutyauripo
Nursing and Midwifery Council:	Represented by Alicia Harrison, Case Presenter
Keshwaree Ramana:	Present and unrepresented
Order being reviewed:	Suspension order (6 months)
Fitness to practise:	Impaired
Outcome:	**Suspension order extended for (3 months) to come into effect on 4 December 2025 in accordance with Article 30 (1)**

Decision and reasons on review of the substantive order

The panel decided to impose a further suspension order for a period of 3 months.

This order will come into effect at the end of date 4 December 2025 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the second review of a substantive suspension order originally imposed for a period of twelve months by a Fitness to Practise Committee panel on 3 May 2024. This was reviewed on 28 April 2025, and a further six-month suspension order was imposed by the reviewing panel.

The current order is due to expire at the end of 4 December 2025.

The panel is reviewing the order pursuant to Article 30(1) of the Order.
The charge found proved which resulted in the imposition of the substantive order was as follows:

> *'That you a Registered Nurse, while a Director at [PRIVATE], which owned and ran the Home* ***between August 2017 and 24 December 2019****:*
>
> *1. Failed to adequately safeguard residents in that you did not ensure that:*
> *a) There were sufficient numbers of suitably qualified staff to meet the service user's needs;*
> *b) Staff had received appropriate training;*
> *c) The Mental Capacity Act 2005 was understood and/or applied by staff;*
> *d) Residents' privacy and dignity was promoted;*
> *e) Residents were provided with a clean and hygienic environment;*
> *f) Residents' nutritional needs were met;*
> *g) Residents' care needs were assessed and/or met;*
> *h) Effective systems was in place to ensure residents' health and safety;*
> *i) Effective systems were in place to safeguard service users from abuse and/or improper treatment.'*

The last reviewing panel determined the following with regard to impairment:

> *The panel considered whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the Nursing and Midwifery Council (NMC) has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally. In considering this case, the panel carried out a comprehensive review of the order in light of the current circumstances. Whilst it noted the decision of the last panel, this panel exercised its own judgement as to current impairment.*
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> *The panel had regard to all of the documentation before it, including the NMC bundle, your reflective piece, your training certificates and testimonials. The panel also had regard to your oral evidence.*
>
> *You told the panel that you are very sorry for your misconduct and that you did not realise that as a registered nurse that you still had a duty of care as a director of [PRIVATE].*
>
> *You told the panel that since qualifying as a registered nurse in 2004, you have never had any issues or complaints against you, and in running a care home since 2010, that you have also never had any issues.*
>
> *In reply to panel questions, you told the panel that you keep up to date with current nursing practice through seminars and online webinars provided by the Royal College of Nursing (RCN) and that you have not carried out any clinical practice in the last 12 months due to your suspension order. You also told the panel that you have not carried out any other work in a nursing environment, for example as a health care support worker, as you did not want to break your suspension order.*
>
> *The panel asked if the hospital and the nurse bank that you previously worked for and at knew that your PIN had been suspended. You replied that*

you had not told them as you felt very emotional and sad about the outcome of your hearing.

The panel asked what you would do to rebuild trust in the nursing profession and within the public. You told the panel that you would follow guidelines and procedures, do training and development. You also told the panel that you would respect everyone and their dignity, listen to your supervisor and work on your self-development.

When pressed on the point, you reaffirmed that neither the hospital nor the nurse bank knew that you had been suspended as a result of the findings in the substantive hearing. You told the panel that they did not know because you were working as a member of bank staff and that you were not a permanent member of staff.

The panel also asked you to clarify if you still view your misconduct as one mistake. You told the panel that you separated your role as a nurse and as a director and that you did not know that as a director you needed to be involved with duty of care as a nurse would be. You stated that you now understand and acknowledge that this was a mistake.

The panel has taken account of the submissions made by Ms Kirwan on behalf of the NMC. She directed the panel through the background of the case and submitted that you have not discharged the persuasive burden to demonstrate to the panel that you are no longer impaired.

Ms Kirwan reminded the panel that the concerns about the matters found proved in this case were serious and wide ranging and that residents were put at risk of physical, psychological and emotional harm as a result of your misconduct.

Ms Kirwan submitted that you repeatedly sought to minimise the issues found proved, including regarding your misconduct as "one mistake" and regarding that mistake as being in the role of a director and not a nurse. Ms

Kirwan submitted that this represented not only a minimisation of what were very serious issues, but also shows a lack of insight into and lack of understanding of the matters found proved.

Ms Kirwan further submitted that the reflective statement provided by you does not focus sufficiently on the concerns of this case and you do not detail how you have put into effect, practical and effective strategies as a director of a care home, such that your misconduct would not be repeated.

Ms Kirwan submitted that of the training certificates provided, only one certificate shows a pass mark. The other training certificates provided do not show a pass mark and this training appears to be all conducted online. It is not clear what you have learnt from these training courses and how they relate to the specific issues in this case.

Therefore, Ms Kirwan submitted that a finding of impairment on the grounds of public protection and public interest is necessary in order to uphold the proper standards of conduct and to maintain confidence in the nursing profession and in the NMC as a regulator.

Ms Kirwan invited the panel to consider a further suspension order as the most appropriate and proportionate sanction. She submitted that not all of the concerns about your conduct have been remediated and that a further period of suspension would allow you to have further opportunity to strengthen your practice and develop the insight into your misconduct. Ms Kirwan further submitted that another suspension order is necessary to protect the public, mark the seriousness of the misconduct and in doing so, would send a message to the public and the nursing profession a clear message of the standard of behaviour required of a registered nurse.

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

The panel considered whether your fitness to practise remains impaired.

The panel considered all of the evidence before them. It noted that the original panel found that you had insufficient insight.

Whilst the panel acknowledged that you apologised and showed remorse for your misconduct and expressed emotion, it considered that your insight remains limited.

In considering whether you have taken steps to strengthen your practice, the panel took into account the recent training that you have undertaken which includes one on 'safeguarding' that was assessed and completed over a period of seven months. The panel noted that some of the courses that you have undertaken relate to the matters found proved; however, you have not provided any reflections about the courses, what you have learned from them and how you intended to apply that learning to your current or future practice.

You provided the panel with testimonials and a written reflective statement. Whilst the testimonials speak to your character and personal qualities, they do not speak directly the matters found proved. While you recognise the importance of your duty of care, there remained a lack of insight into the potential impact of your misconduct on residents, many of whom were vulnerable, their families, staff in the home and the impact on the profession and wider public confidence. In light of this, the panel considered that there was still a risk of repetition of your misconduct.

Further, you told the panel that the authors of the testimonials were not aware of the NMC investigation, hearing or the outcome of your substantive hearing. You justified your decision to not tell the testament authors about the proceedings and your suspension, by telling the panel that the matters are not relevant as they relate to a different care home. The panel rejected this explanation. This further supported the panel's view that your insight is limited with regard to your duty of care and the need to put patients first at all times.

Further, in regards to your written reflective statement, whilst it expressed your remorse and some understanding of your duty of care, it does not provide any information or an understanding of how what you did was wrong, how your actions put residents at risk of harm, what the potential consequences were for residents, staff, the wider public and the nursing profession. Further, there is a lack of information explaining what you have learnt from your reflections, and studies. You have not said what you would do differently in the future and how you plan to utilise these developments in your practice. The panel could not be assured without this level of detail that there would be no repetition of your misconduct. The panel found your reflective statement to be aspirational and couched in general terms.

The original panel determined that the matters found proved were remediable and that your misconduct could be addressed. Today's panel found that your misconduct is still remediable. However, in light of your lack of insight, and the lack of any nursing practice/ experience during the period of your suspension order, you are liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the ground of public protection.

The panel bore in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required

For these reasons, the panel finds that your fitness to practise remains impaired.

The last reviewing panel determined the following with regard to sanction:

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 or would it provide public protection.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where 'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest. The panel was not able to formulate conditions of practice that would adequately address the concerns relating to your misconduct and your lack of insight into the charges.

The panel considered the NMC guidance, 'Suspension Order' (Ref SAN-3d), regarding the imposition of a further period of suspension. It found that due to the seriousness of the matters found proved, and in the order to maintain public protection, that your temporary removal from the register remains necessary. Further, it was of the view that a further period of suspension would allow you further time to fully reflect on your previous failings.

The panel recognised that while you have taken some steps to strengthen your practice through completing various training courses, you have failed to

follow all the recommendations as set out by the previous panel, particularly relating to your reflection on the sub paragraphs of the charge.

The panel concluded that a further 6 month suspension order would be the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a suspension order for the period of 6 months would provide you with an opportunity to take further steps to strengthen your practice and gain further insight into your misconduct. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 4 June 2025 in accordance with Article 30(1)

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

Any future panel reviewing this case would be assisted by:

- *Continued engagement with, and attendance at the NMC review hearing;*
- *A comprehensive reflection using a recognised model specifically addressing the sub-paragraphs of the charge;*
- *Evidence of any self-directed learning;*
- *Evidence of learning from any training you have undertaken, which relates to the charges found proved and in particular, how you have strengthened your practice;*

- *Up-to-date testimonials or references speaking to your current practice including references relating to your current case and its findings, including from stakeholders.*

At the first review hearing, the reviewing panel found that your insight was not yet complete and made a finding of impairment on both public protection and public interest grounds. That panel extended your suspension by a period of six months.

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the Nursing and Midwifery Council (NMC) defines fitness to practise as a registrant's ability to practise safely, kindly and professionally. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel had regard to all of the documentation before it, including the NMC bundle, your reflective piece, your training certificates and testimonials. The panel also had regard to your oral evidence.

Ms Harrison asked the panel to consider imposing a further suspension or striking-off order.

Ms Harrison provided the panel with the summary of the case and reminded it of the decision of the previous panel. She submitted that there is insufficient evidence before this panel to demonstrate that you have addressed the regulatory concerns or taken sufficient steps to strengthen your practice since the imposition of the order.

Ms Harrison submitted that whilst you have continued to engage with the regulator during these proceedings and provided a reflective statement, your reflective statement does not adequately or specifically address each of the charges found proved. She submitted that

your reflective piece addresses general principles and does not specify how you intend to implement these in your practice.

Ms Harrison acknowledged the training you have undertaken and submitted that the only relevant and new training certificate since the last review is that of safeguarding and protection of adults. She submitted that the safeguarding training you undertook was an e-learning training to which there is no obvious mechanism of assessment, and there is no reflection of how the training strengthened your practice or aid your insight. She added that a number of the trainings were completed on the same day, and it is unclear if they were self-directed or done to tick the box as periodically expected.

Ms Harrison submitted that whilst there have been testimonials provided, they only speak to your character, are couched in more general terms and do not specifically address the findings in your case.

Therefore, Ms Harrison submitted that a finding of impairment on the grounds of public protection and public interest is necessary in order to uphold the proper standards of conduct and to maintain confidence in the nursing profession and in the NMC as a regulator.

Ms Harrison invited the panel to consider further suspension or striking off orders as the most appropriate and proportionate sanctions. She submitted that there is no evidence to suggest that you have sufficiently remediated. She added that you have been suspended for a period of time and have engaged with proceedings but in limited ways. She further submitted that as such, the panel might be minded that a further suspension will not achieve anything. She also added that the panel may choose to continue the current order for you to continue to build upon your practice, learning and develop further insight.

Ms Harrison further submitted that an order remains necessary to protect the public, mark the seriousness of the misconduct and in doing so, would send a message to the public and the nursing profession a clear message of the standard of behaviour required of a registered nurse.

You told the panel that you have undertaken two courses in safeguarding adults with one being in December 2024 and another one in August 2025 which is mandatory e-learning. You explained that you can only retake the training upon expiry. You told the panel that you did coursework as part of the December 2024 training, were assessed by an assessor and learned a lot.

You told the panel that you are very sorry for your misconduct and that you realised that you have learned a lot from this experience. You told the panel that you are no longer impaired and can practice safely as a nurse. You said that since the referral was made, you have been working as a home manager, and you have not repeated any of the mistakes found proved.

You told the panel that you now understand your professional obligations, reflected deeply on the circumstances that led to the proceedings, and you take full responsibility for your failings. You explained that at the time you became director, you were not aware of the entire scope of your role, but you have now taken positive steps to understand your role and to ensure that this situation will never happen again. You also said that you are no longer impaired and that the public can trust you.

You told the panel that you recognise that it is your duty to promote, safeguard and protect the well-being of those in your care, and fostering a culture of safety, trust and transparency within your practice and organisation. You told the panel that you remain committed to the professional standards set out by the NMC code, and you will continue to deliver safe, effective and compassionate care whilst maintaining professionalism.

You told the panel that since qualifying as a registered nurse, you have never had any issues or complaints against you, and in running a care home, that you have also never had any issues prior to these proceedings.

In response to panel questions when asked to expand on your written reflection and to be more explicit as to what activity you had undertaken since the last review relating directly to the charges, you explained the following in summary;

- You said in your current role you now employ a risk assessment tool based on individual patient need (the ‘Independence’ Tool) to calculate the number of staff necessary to ensure the safe care of patients.
- You conduct induction training for all new staff on the safeguarding policy and the Mental Capacity Act.
- You said that privacy and dignity of residents was upper most in your activities. Your approach is based on individual care plans which cater for things such as assistance with communication for those without speech, choice of meal types, personal preference around hygiene/medication administration/vaccinations and medical appointments.
- You monitor cleanliness and hygiene via a regime of daily inspection and audit
- Residents nutritional needs are governed by their own choices and are more extensive than previously. There is also a nutritional care plan developed so that staff are aware of these needs.
- Resident’s families are more closely involved in care plans directing the care management of their loved ones.

In response to a question from Ms Harrison, you explained that you work as a manager at the home and undertake mandatory safeguarding training on a yearly basis. You added that you also completed an independent safeguarding training to gain more knowledge on the subject for which you had to sit an exam.

The panel also had regard to your oral evidence.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired.

The panel considered all of the evidence before it. It noted that the original panel and the reviewing panel found that you had insufficient insight.

In considering your insight and whether you have taken steps to strengthen your practice, the panel noted that you provided a reflective statement. However, it noted that this was not done using a recognised model and does not specifically address the sub-paragraphs of the charge. It added that whilst there is some development in your insight, your reflection was general and lacked specific examples and there is no detailed action plan of how you would do things differently in the future.

The panel took into account the evidence of your self-directed learning and acknowledged the recent training you undertook dating back to December 2024. It noted that some of the training undertaken since the last review does not specifically relate to the matters found proved. The panel added that during your oral evidence, you showed a developing insight into your failings and how the training you have undertaken will assist you in doing things differently in the future. It noted that you have not demonstrated this clearly in your reflective statement, and it has noted that the point you made in your oral evidence would be useful in your reflective statement. Much as the panel could see clear progress around the examples you provided and how they had begun to relate to the charges, they still felt you lacked a true depth of insight regarding your full responsibilities as a nurse who was a director in a care home. They determined your considerations were very operationally focussed, too immediate and lacked the necessary strategic vision which would guarantee the ongoing and long-term safety of patients in your care.

In particular the panel determined your commentary which intended to address the issue - ‘to safeguard service users from abuse and/or improper treatment’ – to be entirely reactive and superficial. You said you would immediately report any matters of abuse to the CQC, NMC or police for investigation but were unable to say that you had any effective systems in place to proactively identify the potential for and prevent ill treatment before it actually happened.

The panel could not be assured without this level of detail that there would be no repetition of your misconduct.

You provided the panel with testimonials and a written reflective statement. Whilst the testimonials speak to your character and personal qualities, they do not speak directly the

matters found proved. While you recognise the importance of your duty of care, there remains a lack of insight into the potential impact of your misconduct on residents who were vulnerable, their families, and the impact on the profession and wider public confidence. In light of this, the panel considered that there was still a risk of repetition of your misconduct.

The last reviewing panel determined that you were liable to repeat matters of the kind found proved. Today's panel has received documentation and heard oral evidence from you. In light of this, this panel determined that you are liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is required.

For these reasons, the panel finds that your fitness to practise remains impaired.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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 or would it provide public protection.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not

restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved, the nature of the misconduct and the nature of the shortcomings in your remediation. It concluded that a conditions of practice order could not be formulated which would be appropriate would adequately protect the public and satisfy the public interest.

The panel considered the NMC guidance, '*Suspension Order*' (Ref SAN-3d), regarding the imposition of a further period of suspension. It found that due to the seriousness of the matters found proved, and in order to maintain public protection, that your temporary removal from the register remains necessary. Further, it was of the view that an extended period of suspension would allow you further time to remediate your misconduct.

The panel recognised that while you have taken some steps to strengthen your practice through some reflection and completing various training courses, you did not comply fully with the recommendations of the last reviewing panel which has left a gap in the remediation process.

The panel concluded that a further 3-month suspension order would be the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice. The panel noted that this will allow you sufficient time to directly address the sub-charges in your reflective statement.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly,

the panel determined to impose a suspension order for the period of 3 months would provide you with an opportunity to take further steps to articulate the level of insight you have achieved in your reflective statement. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 4 December 2025 in accordance with Article 30(1)

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

Any future panel reviewing this case would be assisted by:

- Continued engagement with, and attendance at the NMC review hearing.

- Reflection - A comprehensive reflection piece using a recognised model specifically addressing the sub-paragraphs of the charge. Using a model recognised within the nursing profession (such as *Gibbs*) might serve to steer your thinking and add depth to your reflection. In particular you may wish to consider more thoroughly the impact of your shortcomings on the residents and their families, and what actions you might take in future to prevent recurrence.

- Learning **–** you need to be able to articulate far more comprehensively firstly what training you have conducted, and secondly how that training cumulatively serves to develop your knowledge of safeguarding and addresses the charges. You might want to consider more specifically your involvement with developing safeguarding policy, implementing such policy and evaluating its effectiveness at a strategic and tactical level.

- Testimonials – your testimonials should wherever possible be relevant to your practice as a safeguarding senior leader and from independent observers. These might include from visiting district nurses, GPs or other health professionals. You might consider comment from individuals in your care or their families. Testimonials

are likely to be more compelling if they directly comment on your shortcomings outlined in the charges.

This will be confirmed to you in writing.

That concludes this determination.