Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 6 October – Tuesday 28 October 2025
Monday 23 March – Wednesday 25 March 2026

Virtual Hearing

Name of Registrant:	Dhanwati Ramdarass
NMC PIN:	76B0005E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing (Level 1) – 01 April 1981 Registered Nurse – Sub Part 2 Mental Health Nursing (Level 2) – 29 November 1976
Relevant Location:	Hertfordshire
Type of case:	Misconduct
Panel members:	Rachel Onikosi (Chair, lay member) Vivienne Stimpson (Registrant member) Matthew Wratten (Lay member)
Legal Assessor:	Angus Macpherson (6-28 October 2025) Ian Ashford-Thom (23-25 March 2026)
Hearings Coordinator:	Amira Ahmed (6 October 2025) Rene Aktar (7 October 2025) Amira Ahmed (8-9 October 2025) Ekaette Uwa (10 October 2025) John Kennedy (13-17 October 2025) Peaches Osibamowo (20-28 October 2025 and 23-25 March 2026)
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter

Ms Ramdarass:	Present and represented by Louise Hartley instructed by Stephenson's Solicitors
Facts proved:	Charges 1a, 1b, 2, 5, 7ai, 7aiii, 9, 10, 11, 12, 13, 14a, 14b, 15a, 15b, 15c, 17, 18a, 18b, 18c, 18d, 19a, 19b and 20
No Case to Answer:	Charges 3, 4, 8c and 16.
Facts not proved:	Charges 6, 7aii, 8a and 8b
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse and also the Registered Provider and Nominated Individual of [PRIVATE] ("the Home"):

1. As of 28 June 2022 you:

    a. failed to ensure that you had completed up to date medication administration training or alternatively failed to ensure that a record of such training was kept at the Home

    b. failed to ensure that all staff within the Home had completed up to date medication administration training

2. As of 28 June 2022 you failed to ensure that staff completed a risk assessment to address health and safety issues arising from the condition of Resident A's bedroom

3. As of 28 June 2022 you failed to ensure that risk assessments were completed within the Home in relation to food hygiene practices

4. As of 28 June 2022 you failed to take steps to identify poor practice within the Home in relation to food safety and hygiene

5. As of 28 June 2022 you failed to take steps to ensure that risk assessments for Residents C and B contained sufficient detail

6. As of 28 June 2022 you failed to ensure that staff followed Resident B's care plan requirement for the use of a splint

7. You failed to ensure that the risk of infection was adequately controlled in the Home in that:

a. On 18 May 2022 and/or 28 June 2022:

i. one or more staff and visitors did not wear masks

ii. the kitchen in the Home was not adequately clean

iii. Resident A's room was not adequately clean in that wipes containing faecal matter were located on the floor

8. On a date prior to 28 June 2022 you failed to ensure that staff completing pre-admission assessments and care planning at the Home did so to the required standard in that:

a. pre-admission assessments did not adequately consider prospective service users' needs

b. care plans did not contain sufficient information about service users' likes and dislikes

c. Resident A's breathing and circulation care plan lacked sufficient detail

9. On one or more occasions prior to 28 June 2022 you failed to ensure that effective audits were carried out in the Home

10. Between approximately February 2019 and June 2022 you failed to ensure that the fire risk within the Home was adequately managed

11. On one or more occasions prior to 28 June 2022 you did not ensure that one or more staff members at the Home received adequate training for their role

12. On one or more occasions prior to 28 June 2022 you did not ensure that the Home had sufficient staffing levels

13. As of 18 May 2022 you failed to ensure that the Home was registered with Environmental Health

14. You failed to ensure that residents were adequately safeguarded in the Home in that:

    a. on a date prior to 28 June 2022 a safeguarding referral was not made in relation to Resident A's falls

    b. on a date prior to 28 June 2022 a timely safeguarding referral was not made following an incident involving Resident B on or around 5 April 2022

15. You failed to ensure that a multi-disciplinary team approach was taken in relation to the care of one or more residents in the Home in that:

    a. physiotherapy and/or occupational therapy input was not sought for Resident B

    b. an occupational therapy referral was not made for Resident C

    c. mental health input was not sought for Resident A

16. On one or more occasions prior to 28 June 2022 you admitted or allowed to be admitted into the Home residents under the age of 65 when you knew that the Home was only authorised to provide care to residents over the age of 65

17. As of 28 June 2022 you failed to ensure that one or more staff in the Home had a sufficient understanding of the principles around mental capacity and/or the Mental Capacity Act 2005 and/or Deprivation of Liberty Safeguards

18. As of 28 June 2022 you failed to ensure there were adequate systems in place in relation to mental capacity and deprivation of liberty in that:

    a. Resident A's access to her mobile phone and tablet were inappropriately restricted

    b. Resident A was coerced into signing a behavioural plan

    c. one or more of Resident A's requests to go into the community were not facilitated

    d. Resident B's mental capacity was not properly assessed and/or she was kept at the Home without legal authority

19. You used or permitted to be used discriminatory language within Resident A's care records including but not limited to you writing the following:

    a. *'Overall she displayed the physically sick Resident A'*

    b. *'… resting in bed at the time of report writing in her usual floppy bodily display*

20. On a date prior to 28 June 2022 you failed to ensure that consent was obtained from residents or their representatives before installing CCTV in the Home

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

Submissions on no case to answer

At the close of the Nursing and Midwifery Council's (NMC) case, Ms Hartley, on your behalf, made submissions under Rule 24(7) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) that there is no case to answer in respect of Charges 3, 4, 8c, and 16. She submitted that in relation to the test set out in the case of *R v Galbraith* [1981] 1WLR 1039 there is not sufficient evidence upon which a panel properly directed could find these charges proved. She also made reference to the case of *R (Sharaf) v GMC* [2013] EWHC 3332 (Admin).

With regard to Charge 3, Ms Hartley submitted that the evidence of Witness 1 and Witness 2 is inconsistent about the necessity of the formal risk assessment. Moreover, she submitted that Witness 1's evidence was both about the lack of policy and procedure and risk assessments whereas Witness 2 said there was no formal requirement. She therefore submitted that, as there is insufficient evidence to prove that there was a duty on you to carry out the formal risk assessment, the evidence is insufficient to find this charge proved.

In regard to Charge 4, Ms Hartley submitted that the date charged related to the second visit by Witness 1 and that they acknowledged in evidence that by the date of this second inspection, there were no ongoing concerns and the issues they had previously identified had been rectified. Therefore, she submitted that there is no evidence upon which this charge could be found proved; she submitted that the information from Witness 1 actually suggests that, by the date in question, the concerns had been rectified.

In regard to Charge 8c, Ms Hartley submitted that the care plan for Resident A is not in evidence and the NMC had not called any witness to state what was in the care plan, what should have been included and what was missing. She submitted that given the absence of the care plan, there is insufficient evidence to find this charge proved. Ms Hartley submitted that while your colleague has made admissions to a similar charge, this has little to no evidential value in finding this charge against you

proved and therefore should not be used as evidence in support of finding Charge 8c against you proved.

In regard to Charge 16, Ms Hartley submitted that the Statement of Purpose for the Home in 2010 is not in evidence and therefore it is not possible for the panel to be satisfied as to whether the Home was or was not authorised to care for residents under the age of 65. Further, she noted that funding authorities were content to place residents under the age of 65 in the Home the period following registration. She submitted that, given this uncertainty, it is not clear whether you knowingly admitted residents to the Home in breach of its registration. Therefore, she submitted, there is not sufficient evidence to find this charge proved.

In regard of Charge 3, Mr Kennedy, on behalf of the NMC, accepted that the evidence is contradictory. However, he invited the panel to prefer the evidence of Witness 1 and find that there is sufficient evidence upon which the charge could be found proved, and that issues relating to the differences in the evidence of Witness 1 and Witness 2 are better decided at the later facts stage.

In relation to Charge 4 Mr Kennedy submitted that the panel has been directed to the date set out in the charge and as the evidence suggests the issues had been resolved by that time. He conceded that there was no case to answer.

In regard of Charge 8c, Mr Kennedy noted that Witness 2 makes reference to the care plan in the report and that, when taken at its highest, the panel might consider that sufficient to make a decision on whether the charge can be found proved. He made reference to the case of *Professional Standard Authority for Health and Social Care v NMC and Jozi* [2015] EWHC 70 (Admin) and reminded the panel that it may request more evidence on this point to ensure that it is able to discharge its responsibility to protect the public.

In regard of Charge 16, Mr Kennedy explained that it has not been possible to obtain the Statement of Purpose for the Home at the relevant time in the charge. Therefore, he conceded that there is not sufficient evidence for the panel to find this charge proved.

The panel accepted the advice of the legal assessor.

Decision and reasons on no case to answer

In relation to Charge 3, the panel noted that the evidence is inconsistent; with Witness 1 and Witness 2 provided differing accounts. However, the panel determined that the main issue is whether you, as a registered nurse, had a duty to carry out these risk assessments. The panel heard from Witness 2 that they did not believe you had an obligation to conduct these risk assessments. The panel noted that the NMC did not rely on any particular regulations in support of this charge. The panel considered that Witness 2's evidence coupled with the absence of any documentation on this was compelling. Therefore, the panel concluded that the NMC could not prove that you were not under an obligation to carry out risk assessments in the Home in respect of food hygiene and therefore there is no likelihood that the charge could be found proved.

In regard of Charge 4, the panel noted that the date in the charge is in respect of the second visit by Witness 1. The panel noted that, while at the time of the first visit it is likely that there were concerns in relation to food safety and hygiene, as supported by the report of Witness 2, by the time of 28 June 2022, the evidence suggests that these concerns had been suitably addressed. Therefore, the panel considered that there is insufficient evidence to support a finding of this charge being proved as such there is no case to answer.

The panel considered Charge 8c and noted the submissions of Mr Kennedy in relation to adducing new evidence. The panel paused its deliberation on the no case to answer submission until it had determined whether to allow the care plan into evidence.

The panel noted that, for Charge 16, Mr Kennedy acknowledged that the NMC had not adduced the Home's Statement of Purpose and therefore there is no evidence to state that the Home was not authorised to care for residents under the age of 65, nor that you knew this was the case. The panel did note that during this period funding

authorities had referred people under the age of 65 to the Home. The panel therefore considered that there is insufficient evidence upon which it might find this charge proved.

Application to adduce additional evidence

During the deliberations on the submission of no case to answer for Charge 8c, the panel considered whether to use its powers to allow additional evidence to be adduced pursuant to Rule 31. The additional evidence the panel sought was a care plan mentioned in the report of Witness 2. The panel invited parties to make submissions on this. It was agreed that in order to make a proper decision the panel would need sight of the document. If it decided not to admit the evidence, it would be put it out of its collective mind so that it would play no further part in its considerations.

Ms Hartley submitted that the additional evidence should not be admitted. She submitted that while it is relevant to Charge 8c, it should not be admitted due to a lack of fairness to you. She submitted that while the document was included in the Case Examiners Report, since at least the end of 2024 it has been clear that the NMC were not going to rely on this evidence in support of the case against you. She submitted that in a December 2024 Case Management Hearing when the NMC set out the evidence matrix, it was clear that for Charge 8c the NMC only intended to rely on the report of Witness 2 and that you have prepared a defence on that basis. She submitted that to adduce new evidence that this stage, after Witness 2 has already been subject to cross examination, would be unfair to you. In response to panel questioning Ms Hartley confirmed that while she may have considered recalling Witness 2 should the evidence be admitted, given the likely delay in recalling a witness and the potential for further delay in concluding this case, this could cause prejudice and unfairness to you.

Mr Kennedy referred the panel to NMC Guidance DMA-6 and observed that it is within the panel's power to admit evidence at this stage. He submitted that as the panel has identified this evidence as being relevant to Charge 8c, and that you have been provided with a copy of the evidence in the Case Examiners Report, the over-

arching objective of the NMC's Fitness to Practise Committee to protect the public should outweigh any potential disadvantage to you. He agreed that it may be difficult to recall a witness at this stage, but that should the evidence be admitted as evidence the NMC will not place any weight on the lack of cross examination on it.

The panel accepted the advice of the legal assessor.

The panel determined that while it is clear the additional evidence would be relevant to Charge 8c, and that you have been provided with a copy as part of the Case Examiners Report, there would be unfairness in admitting it at this stage. The panel considered that you have not been able to cross examine either witness on the content of the evidence, and that in order to do so there would likely be a substantial delay in the case which would be highly unfair to you as the events already relate to dates some three years ago. The panel noted that at no stage of the case management meetings was it suggested by the NMC that they would rely on this evidence in finding Charge 8c proved. The panel also note that within the report of Witness 2, who reviewed the document, they make reference to another document that was reviewed and contributed to the final report. The panel determined that should the care plan be admitted you would be disadvantaged by the lack of context surrounding its origin and a lack of any witness testimony to provide greater context to the documentary evidence.

While there is a public protection concern in ensuring the case is fully explored the panel determined that in light of the above, admitting the evidence at this stage would unduly prejudice you and therefore determined not to admit the additional document into evidence.

Reconsideration of no case to answer on Charge 8c

Having made its decision on admitting new evidence the panel returned to consider the no case to answer submissions on Charge 8c.

The panel determined that there is no documentation before it to detail what the care plan consisted of, or what should have been included and what allegedly was

missing. The panel noted that while Witness 2 makes reference to this point in their report, the evidence is weak as it appears to reference further documentation that is not before the panel to consider. Therefore, the panel determined that the second limb of *Galbraith* is engaged in this case and that there is no case to answer in regard of Charge 8c.

Background

The charges arose whilst you were employed as a registered nurse and the Registered Provider of [PRIVATE] ("the Home"). A referral was received from the Care Quality Commission (CQC) on 26 July 2022.

On 18 May 2022 a CQC inspector carried out an inspection of the Home and found evidence of serious failings to ensure the safe and adequate care and treatment for service users.

The CQC raised the following concerns with the NMC which were translated into the above charges.

Residents' experience of using this service was found to be inadequate.

There were not enough skilled staff deployed to meet residents' needs safely and effectively. Fire risk concerns that the registered manager and the registered provider were made aware of by fire safety specialists had not prompted them to reassess the level of risk to which residents were exposed to in case of a fire. The level of risk to residents' health and safety from living in an unsafe environment with clutter, trailing wires and poor infection control procedures was not assessed or mitigated.

Risk assessments in place for identified health needs lacked sufficient guidance for staff on how to reduce risk and help keep residents safe.

Residents were not supported to have maximum choice and control of their lives. Staff did not support them in the least restrictive way possible and in their best

interests; the policies and systems in the service did not support best practice. A resident had numerous restrictions applied to their freedom. The registered manager and the registered provider imposed these restrictions without having the legal authority to do so. In addition, residents were denied the use of their own phones, and computers and were denied help with on-line shopping if their behaviour was considered inappropriate by the registered manager or the registered provider.

The registered manager and the registered provider had failed to implement rehabilitation guidance residents were given when discharged from hospital. Residents' needs were not reviewed and, except for the GP, specialist external health professionals' input into residents' care was not requested. Staff were not trained to understand and meet residents' needs. Staff received "all-in-one" training consisting of 13 subjects delivered in one day. Staff's competence or understanding of their training was not assessed.

The lack of skills of the staff prevented them from supporting residents in a kind and compassionate way. The CQC Inspector observed that staff were respectful when talking to residents. However, the language and terminology used by management when talking about residents and the language used in their care plans evidenced a labelling, discriminative approach towards those with protected characteristics.

The care and support residents received was routine-led, based and centred around their basic needs only. Staff were overstretched completing tasks like meal preparation, housekeeping and supporting residents with their care needs. This meant that they had limited or no time to organise meaningful activities, to support residents to go out or to spend time talking to them.

Staff's knowledge about safeguarding was poor, and the registered manager and the registered provider failed to recognise and report safeguarding concerns. Protection plans for residents were not implemented, and they were left at risk of further abuse.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Hartley who informed the panel that you made full admissions to charges 1a, 1b, 7ai, 7aiii, 9, 10, 11, 12, 13, 14a, 14b, 17, 18a, 18c, 19a, 19b, 20.

The panel therefore finds charges 1a, 1b, 7ai, 7aiii, 9, 10, 11, 12, 13, 14a, 14b, 17, 18a, 18c, 19a, 19b, 20 proved in their entirety, by way of your admissions.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kennedy and Ms Hartley. We also heard from Ms Mulhern, who represented Colleague 2.

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: Care Quality Commission Inspector
- Witness 2: Registered Mental Health Nurse commissioned by Somek and Associates to provide expert opinion

The panel also heard evidence from you under oath.

As these proceedings were joined with those of Colleague 2, the panel also heard and took into account live evidence from:

- Colleague 2 — Registered Nurse and Manager of the Home

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

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

Charge 5

> ‘’That you, a registered nurse and also the Registered Provider and Nominated Individual of [PRIVATE] (“the Home”):
>
> As of 28 June 2022 you failed to take steps to ensure that risk assessments for Residents C and B contained sufficient detail’’

This charge is found proved.

In reaching this decision, the panel took into account your oral and written evidence and the oral and written evidence of Witness 1 and Witness 2.

In relation to Charge 5, Witness 1 stated that the risk assessments relating to the hoisting of residents would note that a hoist or sling was needed for Resident C and Resident B but they did not specify what level of hooks to use. She stated that this *‘was a concern as risk assessments and plans of care should give comprehensive, clear and unambiguous guidance for staff when using hoists, which should include the number of staff required, model of hoist, type and size of sling and which loops or hooks (which are of different lengths) are to be used to attach the sling to the hoist’.* This was broadly reflected by Witness 2.

In oral evidence, you stated that you were a manual handling trainer, each resident had a bespoke sling with hooks, all staff knew what to do and received the relevant training, unless signed off as competent you would not allow staff to engage in manual handling. You said you would talk through the process with staff and give them handouts. You stated that the slings were universal and that the straps were set when residents arrived and were not adjusted. Although the details regarding the level of hooks to use were not included in the risk assessments, you said that staff members knew what to do, that it was safe and that no agency staff were employed during the period. You stated that it would be useful to have a risk assessment for the hoist and slings in the residents' files.

Although the panel did not see the risk assessment, it was satisfied that the details regarding the hooks were not included. The panel decided that the exclusion of this detail rendered the risk assessment insufficient, particularly, as the risks attached to the manual handling and movement of residents are so serious. The panel determined that all staff members should have access to clear written instructions regarding the use of slings and hoists as part of the manual handling process for relevant residents. As you were the Registered Provider at the Home, you should have ensured that there were sufficient risk assessments in place to cater for all eventualities.

Therefore, on the balance of probabilities, this charge is found proved.

Charge 6

> **''**That you, a registered nurse and also the Registered Provider and Nominated Individual of [PRIVATE] ("the Home"):
>
> As of 28 June 2022 you failed to ensure that staff followed Resident B's care plan requirement for the use of a splint ''

This charge is found NOT proved.

In reaching this decision, the panel took into account your oral and written evidence, the oral and written evidence of Witness 1 and Witness 2 and Resident B's rehabilitation booklet.

Witness 1 stated that a member of staff was '*unaware of what a splint was'* raising the concern that Resident B's left hand was not being supported as per their rehabilitation plan. The panel saw the documentary evidence that depicted instructions for managing the resident's splint. The panel recognised that the document had ambiguous instructions and included a direction for the splint to be applied to both the left and right hands, even though the splint was only required on the resident's left hand.

The panel noted that the rehabilitation plan stated that the splint should be worn overnight and you stated that it was worn during the day. Your evidence was supported by a note in Resident B's care notes that documented that '*hand support'* had been worn during the day on 22 February 2022. The panel accepted that within the Home the term '*hand support'* also referred to a *'splint'*.

The panel heard from Witness 1 that there should have been a risk assessment for when Resident B was not wearing the splint. Although, it could have been a moment in time that Resident B was not wearing the splint, it did not have sight of any risk assessment in relation to this.

The panel decided that there is evidence that the splint was worn. It therefore considered that staff must have interpreted the care plan so that support was provided for Resident B's left hand. It attached no significance to the conversation which Witness 1 said she had with the unidentified member of staff.

Therefore, on the balance of probabilities, this charge is found not proved.

Charge 7aii

> ‘’That you, a registered nurse and also the Registered Provider and Nominated Individual of [PRIVATE] (“the Home”):

You failed to ensure that the risk of infection was adequately controlled in the Home in that:

a. On 18 May 2022 and/or 28 June 2022:

ii. the kitchen in the Home was not adequately clean’’

This charge is found NOT proved.

In reaching this decision, the panel took into account your oral and written evidence, the oral and written evidence of Witness 1 and Witness 2 and the photographs of the kitchen.

The panel considered the evidence of Witness 1 who stated that the kitchen was cluttered and untidy.

The panel noted that there was no evidence regarding the cleanliness of the kitchen on the dates specified in the charge.

The panel had sight of the cleaning schedule that covered the inspection periods and noted that the photograph upon which Witness 1 relied was in respect of only one side of the kitchen. In your evidence you made reference to the side of the kitchen where food preparation was carried out namely a cooker that had a stainless steel worktop. The panel saw the photograph of the kitchen produced by you. This side of the kitchen is not visible in Witness 1’s photograph.

The panel determined that the kitchen was cluttered but that the NMC had not established that it was unclean.

Therefore, on the balance of probabilities, this charge is found not proved.

Charge 8a and 8b

‘’That you, a registered nurse and also the Registered Provider and Nominated Individual of [PRIVATE] (“the Home”):

8. On a date prior to 28 June 2022 you failed to ensure that staff completing pre-admission assessments and care planning at the Home did so to the required standard in that:

a. pre-admission assessments did not adequately consider prospective service users' needs

b. care plans did not contain sufficient information about service users' likes and dislikes''

This charge is found NOT proved.

In reaching this decision, the panel took into account your oral and written evidence and the oral and written evidence of Witness 1 and Witness 2.

In relation to Charge 8a, Witness 1 stated that the pre-admission assessments were *'generally lacking in detail'* and were not in place to consider prospective user needs. There was no documentary evidence before the panel to support Witness 1's assertions but, in the hearing, she was shown a copy of a blank pre-admission assessment which she said appeared very similar to the forms she had reviewed.

During his oral evidence and when shown a blank pre-admission assessment form Witness 2 said that it contained the relevant information one might expect, and if completed correctly, it was a comprehensive form. He told the panel that without reviewing the forms inspected by Witness 1 he was unable to provide an opinion as to whether they did not adequately consider prospective user needs.

The panel noted that there was no documentary evidence to support this charge and heard your evidence that generally Colleague 2 did the pre-admission assessments; you did very few. However, the decision to admit a resident to the home would be a joint decision.

Based on the lack of documentary evidence to support this charge, and in light of the oral evidence of Witness 2 in relation to the comprehensiveness of the form, the panel determined that there is insufficient evidence to find this charge proved.

Therefore, on the balance of probabilities, this charge is found not proved.

In relation to Charge 8b, the panel had sight of Resident B's lifestyle care plan which contained a few pages setting out likes and dislikes. You stated that the free text box provided an opportunity to reflect on a resident's choices which were also contained in the daily entries. You stated that the existing lifestyle care plan was a scaled down version following guidance from a CQC Inspector in 2017 who stated that the previous iteration was too detailed.

The panel noted that there was not an overall care plan before it that detailed Resident B's daily care requirements and that in the absence of this there was no information to determine whether the lifestyle plan was missing vital information.

The panel determined that there is insufficient evidence to find this charge proved.

Therefore, on the balance of probabilities, this charge is found not proved.

Charge 15

> ‘’That you, a registered nurse and also the Registered Provider and Nominated Individual of [PRIVATE] (“the Home”):
>
> You failed to ensure that a multi-disciplinary team approach was taken in relation to the care of one or more residents in the Home in that:
>
> a. physiotherapy and/or occupational therapy input was not sought for Resident B
>
> b. an occupational therapy referral was not made for Resident C

c. mental health input was not sought for Resident A”

This charge is found proved.

In reaching this decision, the panel took into account your oral and written evidence and the oral and written evidence of Witness 1 and Witness 2.

The panel considered your evidence in which you stated that professionals would often be involved in Resident B’s care. You said that you asked Colleague 2 to make a GP referral but because you did not want to override his authority you did not chase it up. You confirmed that no referral was made.

The panel acknowledged that a physiotherapist did visit Resident B after they had arrived at the home, but they refused to engage. The panel noted that thereafter, you did not ensure that there was a multi disciplinary approach to Resident B’s care prior to the CQC inspection. The panel did not consider that Resident B’s refusal constituted a proper reason not to maintain a multi-disciplinary approach to their care; you should have ensured that further attempts were made to secure for them physiotherapy and / or occupational therapy.

Therefore, this charge is found proved.

In relation to Charge 15b, Witness 2 considered that there should have been an assessment for a shower chair and wheelchair and this was not actioned. Witness 1 referred to a letter dated 20 July 2022, requesting the shower chair, but this was after the date of the inspection.

In your evidence, you stated that the shower chair and wheelchair were promised by the discharging unit, but they later refused to supply them. A referral was made to Occupational Therapy, and they also refused to provide assistance. You could not recall the details or the reasons why Occupational Therapy declined to assist, and you were unable to provide documentary evidence of this. The panel regarded your request for a shower chair and wheelchair in the email in July 2022 to be inconsistent with your assertion that assistance had already been declined.

In the absence of any documentary supporting evidence, the panel concluded that there was no Occupational Therapy referral prior to the inspection; if referrals had been made to the Occupational Therapy team, they would have been presented to the CQC at the facts stage of their investigation. The only documentation produced in relation to this matter post dates the inspection. The panel did not find your account reliable.

Therefore, on the balance of probabilities, this charge is found proved.

In relation to Charge 15c, Witness 1 stated that '*there was a lack of MDT approach with regard to Resident A's mental health needs'*.

The panel made reference to the GP summary and accepted that Resident A refused psychiatric input which resulted in them being referred back to the GP who did not make a new referral. In fact, the panel noted from the GP summary that Resident A did request psychology support in February 2021 therefore it cannot be assumed that Resident A would not consent to further support if offered for her mental health in the future.

The panel considered your oral evidence in which you stated that although Resident A exhibited behavioural issues, she demonstrated capacity, and in consequence she did not require a mental health referral. You stated that Resident A's mental health was kept under review by yourself and Colleague 2; there was no need to seek external assistance because you felt capable, due to you and Colleague 2's experience, of keeping Resident A's mental health under review.

The panel found that as a registered nurse and Registered Provider of the Home your responsibility was to ensure that residents' current and changing health needs were continuously identified and met.

Therefore, on the balance of probabilities, this charge is found proved.

Charge 18b and 18d

‘’That you, a registered nurse and also the Registered Provider and Nominated Individual of [PRIVATE] (“the Home”):

As of 28 June 2022 you failed to ensure there were adequate systems in place in relation to mental capacity and deprivation of liberty in that:

b. Resident A was coerced into signing a behavioural plan

d. Resident B’s mental capacity was not properly assessed and/or she was kept at the Home without legal authority’’

This charge is found proved.

In reaching this decision, the panel took into account your oral and written evidence, the oral and written evidence of Witness 1 and Witness 2, the behavioural intervention plans, the Care Programme Approach (CPA) and the daily notes of Resident A.

In relation to Charge 18b, Witness 1 stated that Resident A told her that she was coerced into signing a behavioural plan. This is supported by Resident A’s daily notes, a contemporaneous document, which states that the resident *‘confirmed to staff that she would rather consent to the current arrangement of requiring escorts than to opt for DoLS, which she thinks will be a stigma’.*

The panel noted a definition of coercion in the Oxford English Dictionary as follows ‘*impelling a person into quiet obedience’*. It heard that Resident A could be challenging and manipulative. However, the panel found that Resident A signed the behavioural plan because she wanted the restrictions to be removed and to avoid the ‘*stigma’* of being on DoLS. This is implicit coercion as Resident A had mental capacity, hence the Home had no legal basis to make a DoLS application at the time, something which was clearly unknown to Resident A. The panel noted that Resident A was not accompanied by a family member during the meeting and those present were you,

Colleague 2 and another member of staff from the Home. The panel considered that this may have placed Resident A under some pressure to sign the CPA.

You stated that you were involved in a lengthy discussion with Colleague 2 who read the plan out to you. You stated that DoLS was not part of the plan and that you do not know how it came to be included. You stated that the referral to DoLS was inappropriate and that you had seen it for the first time during these proceedings.

The panel determined that the threat of Resident A being placed on DoLS in the event they declined to agree to sign the behavioural plan as set out in the CPA, presented Resident A with no real choice but to sign it.

Therefore, on the balance of probabilities, Charge 18b is found proved.

In relation to Charge 18d, Witness 1 was concerned as to whether Resident B had capacity. She had seen, written in their discharge summary: *'lacks capacity in relation to discharge destination and ongoing care needs'*. She had heard Resident B shouting that they wanted to go home. This led Witness 1 to ask Colleague 2 if the resident in fact had capacity. Colleague 2 stated that they had capacity as he carried out an informal assessment when the resident was admitted. Witness 1's evidence is that she questioned Colleague 2 about this because if Resident B had capacity, they were being kept in the Home against their will. On completing a further assessment Colleague 2 concluded that Resident B did not have capacity.

Colleague 2 told that panel that he understood the principles of MCA and DoLS and that he had informally assessed Resident B when they arrived at the Home. He said that Resident B would often shout that they wanted to go home but he considered it was a behavioural issue because when taken outside Resident B would desist in saying those things.

The panel finds that Colleague 2 misunderstood the principles of MCA or DoLS. He carried an informal MCA assessment in relation to Resident B which was not compliant with the statutory requirements and therefore there was no documentation.

The conclusion that he reached that Resident B had capacity had no status. Therefore, he should have carried out a formal MCA assessment to identify whether it was proper to allow Resident B to go home.

The panel determined that you failed to implement adequate systems to monitor the effective use of the MCA and DoLS. Had you done so, Resident B's mental capacity would have been properly assessed by Colleague 2.

Therefore, on the balance of probabilities, Charge 18b is found proved.

In relation to Charge 18d, Witness 1 noted that Resident B was assessed as not having capacity in their discharge summary. There was no proper assessment documented when Resident B was admitted to the home, as is confirmed by Colleague 2.

The panel determined that this shows you failed to ensure there were adequate systems in place in relation to mental capacity and deprivation of liberty. The Mental Capacity Act process is a formal process which must be documented. The panel found that you allowed an informal assessment to be undertaken.

Therefore, in relation to the proper assessment of Resident B's mental capacity, this charge is found 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

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

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

Mr Kennedy identified the specific, relevant standards where your actions amounted to misconduct. Mr Kennedy submitted your conduct breached the following paragraphs of the Code: 1.2, 1.4, 3.1, 3.4, 4.2, 4.3, 5.1, 6.2, 8.2, 8.6, 10, 13.2, 17.1, 17.3, 19.1, 20.1, 20.3 and 20.5.

Mr Kennedy submitted that a general approach to the Dame Janet Smith test applies, and the first three limbs of the test are engaged. He submitted that not ensuring that staff were properly trained risked the wellbeing of the public.

Mr Kennedy submitted that you breached fundamental tenets of the profession and brought the profession into disrepute. He submitted that your behaviour was not what the public would expect of a registered nurse.

Mr Kennedy submitted that the panel should consider your conduct as a whole, including your past behaviour and what has happened since the incident to determine whether there is a risk of repetition in the future.

Mr Kennedy made reference to the case of *Cohen* and submitted that the panel should take into account the need for public protection and wider public interest in this case.

Mr Kennedy submitted that the panel should consider your insight and whether you are currently impaired. He submitted that the panel should decide whether your behaviour is easily remediable and whether it has been remediated.

Mr Kennedy submitted that you were the registered provider and nominated individual at the Home who worked as a nurse with front line responsibilities, as well as oversight responsibilities.

Mr Kennedy submitted that not all breaches of the Code will lead to a finding of misconduct but he submitted that they should lead to a finding of misconduct in this case. He submitted that you were an experienced nurse and manager for many years and you failed in your duties. He submitted that many of the problems that were identified by the CQC should have been identified by you.

Mr Kennedy submitted that you compromised patient safety in not wearing masks all the time, not ensuring that referrals were made, not managing fire risks adequately and your behaviour fell well below the standard expected of a registered nurse and registered manager. He submitted that this amounts to serious misconduct.

Ms Hartley submitted that the panel's decision is to determine whether you can practise kindly, safely and professionally.

Ms Hartley submitted that the allegations arising from the findings from the CQC investigation indicated that you failed to prioritise the safety of those in your care.

She submitted that the findings were serious but they should be put in context, and the systemic issues should be taken into account.

Ms Hartley submitted that you have been a registered nurse for approximately 50 years with no previous adverse findings against you. She submitted that the CQC had inspected previously with mixed outcomes yet none of the findings warranted an NMC referral. She submitted that in a previous CQC investigation your safeguarding knowledge was praised.

Ms Hartley submitted that around the time of the last CQC inspection you were unable to focus on your role at the Home as [PRIVATE] in America and this involved travelling back and forth. She submitted that this meant that you stepped back from some of the oversight elements of the Home, and you accept this was wrong and do not seek to excuse your actions. She submitted that your personal difficulties and the competing demands on your time meant that you delegated more responsibilities to Colleague 2, as you had every confidence in his abilities.

Ms Hartley submitted that Colleague 2 had previously taken a Home from adequate to good and you delegated responsibilities to him as you believed he was competent and capable.

Ms Hartley submitted that the roles of registered manager and nominated individual could be merged. She submitted that it was acceptable to delegate tasks but that there should have been more robust auditing measures.

Ms Hartley submitted that the challenging presentations of some of the residents meant that perhaps some of them should not have been admitted to the Home.

Ms Hartley submitted that you genuinely cared about the residents and they made progress whilst at the Home. She submitted that Resident A began to take care of her appearance whilst at the Home.

Ms Hartley submitted that the Home was praised by a General Practitioner for how they managed Resident A. She submitted that Resident B became more involved in activities with other residents after some time.

Ms Hartley submitted that Witness 1, the CQC inspector, only saw the Home on 2 days, one of which was half a day. She submitted that this was a snapshot in time.

Ms Hartley submitted that you worked clinically caring for residents on a day-to-day basis and this is where your passion lies. She submitted that you have no desire to run a home again and you wish to return to front line nursing, to which you have dedicated your life.

Ms Hartley submitted that some of the processes at the Home were incorrect, but your intentions were right.

Ms Hartley submitted that working conditions were strenuous during the COVID-19 pandemic and there was fear for the vulnerable.

Ms Hartley submitted that there were record keeping issues, which is fundamental in nursing practice. However, she submitted that this should be considered contextually as it was a small home with staff who knew the residents well. She submitted that this was an inbuilt mitigation of risk and no resident contracted COVID during the pandemic.

Submissions on impairment

Mr Kennedy 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. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kennedy submitted that you should be given credit for your admissions to a number of charges as this goes to insight. However, he submitted that you exposed residents to a risk of harm, which goes to public protection.

Mr Kennedy submitted that the wider public interest is also engaged as the public trust nurses and care homes to look after patients. He submitted that you were trusted to look after the complex needs of vulnerable people and you did not carry out tasks as expected of you.

Mr Kennedy submitted that both the public protection and wider public interest grounds are engaged in this case.

Mr Kennedy submitted that your shortcomings are remediable. He submitted that there is evidence of training and positive testimonials. He submitted that you have shown that you have theoretically addressed areas of concern but not shown evidence of a practical demonstration of this.

Mr Kennedy submitted that you have not shown the necessary insight as you were given the opportunity to comment on the impact of your actions during panel questioning and you did not take this opportunity. He submitted that you have not developed full insight, therefore, the risk of repetition remains.

Mr Kennedy submitted that a finding of current impairment is necessary to address the public protection and public interest concerns in this case.

Ms Hartley submitted that you have made a significant number of admissions and demonstrated remorse and reflection.

Ms Hartley submitted that, since the commencement of these proceedings, you have focused on improving your nursing practice. She submitted that you are aware that you have taken a reactive approach to some matters, however you are now committed to being proactive.

Ms Hartley submitted that there is no evidence of actual harm. This case is about the risk of harm and you have taken steps to address this. She submitted that your intention was never to cause any distress, rather you wanted to make a positive impact on those in your care.

Ms Hartley referred to your reflective piece and submitted that there is evidence of genuine, developing and continuing insight.

Ms Hartley submitted that your intention is to return to frontline nursing, you have a deeper appreciation of the standards expected of you as a registered nurse, and a gratitude for the privilege of being a nurse. She submitted that you have no intention of opening a nursing home as a business.

Ms Hartley submitted that you have reflected on what went wrong and you are determined to ensure that those shortcomings are never repeated.

Ms Hartley submitted that you are currently living on your [PRIVATE]. However, she submitted that you are keen and motivated to maintain your practice so that you can return to the profession that you love.

Ms Hartley submitted that you have been fully engaged with these proceedings and those of the CQC.

Ms Hartley submitted that you have provided positive testimonials which describe you as being '*consistently friendly and helpful in person'* and '*professional and responsive when contacted'.*

Ms Hartley submitted that, the panel should consider whether, in light of the steps taken to remediate the concerns, considering your reflections, remediation and testimonials, your fitness to practise is currently impaired.

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 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically: 1.1, 1.2, 1.4, 2.3, 3.3, 3.4, 4.2, 4.3, 5.1, 6.2, 8.6, 10.1, 10.2, 13.2, 17.1, 19.1, 19.3, 19.4, 20.1, 20.3, 20.5, 25.1.

‘***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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.3 encourage and empower people to share decisions about their treatment and care

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

To achieve this, you must:

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

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

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

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

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 cooperatively

To achieve this, you must:

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

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

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

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

To achieve this, you must:

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

In relation to Charge 1a, the panel acknowledged that you produced a certificate that showed that you had been trained at the relevant time. Therefore, the panel found no misconduct in relation to this charge.

In relation to Charge 1b, the panel considered that a key element of service delivery and a fundamental nursing skill is knowing and being trained in the administration of medication. It found that failing to do so amounted to serious misconduct.

In relation to Charge 2, the panel accepted that there were challenges involved in caring for Resident A, keeping her room tidy and using wipes to clean her stoma. The panel heard that you spent a lot of time cleaning her room and trying to keep it tidy. Although a risk assessment was not in place, the panel found that this does not amount to serious misconduct.

In relation to Charge 5, the panel considered that you had oversight of the Home and there should have been clear instructions within the risk assessments to ensure that staff knew exactly which slings and hooks were to be used. The panel found that anything short of this could amount to a serious risk of harm to residents. Therefore, your conduct in relation to this charge amounts to serious misconduct.

In relation to Charge 7ai, the panel noted that during the COVID-19 pandemic there was guidance in place stipulating that face masks must be worn. You failed to do this and therefore failed to reduce the risk of infection in the Home. The panel decided that this amounts to serious misconduct.

In relation to Charge 7aiii, the panel considered that there were challenges with Resident A untidying her room. Although there was a regime in place to ensure that the room was tidied as best as it could be, the panel accepted that there was no way to ensure that the room was always tidy due to Resident A's behaviour. The panel decided that there was no misconduct in relation to this charge.

In relation to Charge 9, the panel accepted that audits were carried out at the Home but that they did not meet the standards expected during the inspection. However, the panel heard very little information about the specifics of the concerns raised during the inspection. Therefore, the conduct in this charge does not amount to misconduct.

In relation to Charge 10, the panel considered that as the nominated individual of the Home, it was your duty to ensure that the risk of fire was safely minimised by having a risk assessment in place. The panel found that the Home was at risk due to your failure to do this risk assessment. The panel determined that this amounts to serious misconduct.

In relation Charge 11, the panel noted that as the nominated individual at the Home you should have ensured that the training at the Home was effective. You had a duty to ensure that there was effective training for staff, and the panel considered that, a one-day training programme was inadequate. You admitted that the training was ineffective. The panel found that this amounts to serious misconduct.

In relation to Charge 12, the panel considered that poor staffing levels could result in poor patient care. Therefore, this is a serious concern and amounts to serious misconduct.

In relation to Charge 13, the panel noted that the commercial kitchen at the Home was catering for vulnerable people who had just been released from hospital care. The panel considered that it was a basic requirement for you to engage with the relevant authorities and comply with environmental health regulations when managing the Home. The panel found that your failure to do so amounted to serious misconduct.

In relation to Charge 14a, the panel considered that Resident A was being cared for by the Home and her fall could have resulted in serious harm. The Home should have considered her vulnerabilities and the potential and risk of harm in not reporting her fall. Therefore, this amounts to serious misconduct. The panel next considered charge 14b, which related to a vulnerable resident who was initially bed bound and had been in various different hospitals. The panel decided that anything that results in injury to a resident should be referred in the interests of the patient's safety. The panel found that the failure to do this amounted to serious misconduct.

In relation to Charges 15a, b and c, the panel considered that all of the residents required extra support and engagement from other service providers. The risk of harm in failing to ensure that a MDT approach was undertaken could have led to a serious risk of harm to the residents by depriving them of additional specialist input to their care. The panel decided that as the nominated provider you had the responsibility to ensure that each resident was assessed accordingly. Therefore, the failings in these charges amounts to serious misconduct.

In relation to Charge 17, the panel noted that you have a responsibility to ensure that Colleague 2 in particular had the required working knowledge of the MCA and DoLS and you failed to do that. This had an impact on the outcomes for Resident A and Resident B as restrictions were not applied appropriately. The panel found that this amounted to serious misconduct.

In relation to Charges 18a and 18b, the panel considered that in your capacity as the nominated individual at the Home you had a duty to ensure that there was a system in place to manage the legalities of DoLSIs. You ought to have ensured that other people were involved in resident A's care and that there was a MDT approach to their care. You had a responsibility to check what was in Resident A's care plan, ensure it was correct and conduct a proper assessment to ensure that the care plan approach was legal and suitable for Resident A. You did not seek the appropriate approval and there were no systems in place, which resulted in restrictions to Resident A's use of her mobile phone and being coerced into signing a care plan approach. The panel determined that the misconduct in charge 18b was aggravated by you being present when Resident A was coerced into signing the care plan approach. The panel determined that this amounts to serious misconduct.

In relation to Charge 18c, the panel accepted your admission that restrictions were placed on Resident A which resulted in her being deprived of her freedom to go outside unaccompanied. The panel found that your failure to ensure adequate systems in relation to mental capacity and DoLS, such as engaging an MDT approach, amounted to serious misconduct.

In relation to Charge 18d, the panel noted that you failed to ensure Colleague 2 had full knowledge of the Mental Capacity Act (MCA), in that an assessment for Resident B was not carried out in compliance with the legal requirements. This resulted in an inappropriate assessment of Resident B's mental capacity and needs prior to formulating a treatment plan. The panel found that this amounts to serious misconduct.

In relation to Charges 19a and 19b, the panel considered that you had no bad intentions and the notes merely exhibited an antiquated and outdated approach to describing residents and clinical matters. You did not intend to discriminate against or breach any resident's protected characteristics. The panel found that this does not amount to serious misconduct.

In relation to Charge 20, the panel considered that you had good intentions in installing the CCTV to protect the residents but you were either unaware or did not take the necessary steps to do this in the manner expected. The panel found that this does not amount to serious misconduct.

The panel found that your actions 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.

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 NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

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

The panel decided that the first three limbs of the test are engaged. The panel finds that patients were put at risk of physical 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 considered that you had an oversight role in relation to vulnerable residents as the registered provider and nominated individual, which carries

considerable responsibility for the health and welfare of residents. Your decision to also work as a nurse alongside this role meant that the oversight responsibilities were impacted and neglected but equally, this advantage should have afforded you the opportunity to identify and address the shortcomings in the Home. The panel's view is that your decision to take on both roles without fully considering your ability to fulfil both responsibilities was an error of judgement.

The misconduct in this case encompassed a wide range of failures, including basic requirements such as adhering to environmental health and safety fire regulations through the systems and processes designed to keep individual residents safe from harm and promote their health and wellbeing. The panel noted that you admitted residents to the Home despite not having the skills or staffing levels to support their individual needs effectively, and you were absent from the Home for periods of time without providing adequate cover to discharge your responsibilities.

Regarding your insight, the panel considered that you showed limited insight into your failings. In your oral evidence it did not seem that you had genuinely reflected on your conduct and that despite the CQC findings and your admissions you still maintained that the level of care you provided was of a high standard and that the CQC had unfairly portrayed the Home in a negative light. You also, on occasions, expressed your reliance on the expertise of Colleague 2 whilst, and when you were absent from the Home. The panel's view is that your response to the concerns raised during the course of the proceedings indicated an attitudinal reluctance to accept your shortcomings.

Although you provide an apology for the inappropriate delegation of your role to Colleague 2, you did not provide adequate insight into how appropriate systems or processes or basic failures would be addressed in the future. You mention your extensive experience in the field of mental health but do not address the significant impact of your failures in respect of the application of the mental health legislative framework and the impact that breaches had on the residents. To your credit, the panel noted, for example that your written reflections included your view on how Resident A's behaviour was managed and that you should have taken a more collaborative approach by working with other professionals. It also acknowledged

your view that whilst mitigation had been put in place, the changes were not rapid. However, inherent in your role was to abide by the principles of good governance for the Home and the panel noted that your reflections do not address the fundamental failings in this respect.

The panel was mindful that some of the incidents took place at the time of the COVID-19 pandemic and that communication within the system was sometimes more difficult.

The panel accepted that some of the regulatory concerns are remediable, however, your lack of true insight into your failings and your attitude did not show that you had truly accepted full responsibility for the range of issues that went wrong which were largely foreseeable and could have been improved and/or mitigated prior to the CQC inspection. The panel was not entirely satisfied that you fully accepted your role in what went wrong and it did not see evidence of adequate remorse from you.

The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether you have taken steps to strengthen your practice. The panel took into account the evidence of training you have undertaken and the steps you have taken to rectify issues since the CQC inspection. Specifically, the panel noted a significant number of training courses that you have completed between 2022 and 2025 in order to improve your skills and competencies as a registered nurse.

However, the panel is of the view that there is a high risk of repetition because your misconduct showed multiple fundamental and basic failings to which you have limited insight and developing reflections. The panel has not seen evidence that you have sufficiently strengthened your practice in light of the wide ranging nature of the failings in this case. The panel therefore decided that a finding of impairment is 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 determined that a finding of impairment on public interest grounds is required because the wide range of fundamental failings and the fact that you were unable to demonstrate adequate remorse and insight into your conduct, calls for such a finding.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Mr Kennedy informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired.

Mr Kennedy submitted that the purpose of a sanction is to satisfy the public protection and wider public interest concerns. He submitted that the sanction must be no more than is necessary and it must be proportionate. He submitted that the panel should first look at the least restrictive sanction.

Mr Kennedy submitted that in terms of mitigation, you have had a lengthy career without concern prior to the CQC inspection. He submitted that aggravating factors in

this case are that you were in a senior management role and there were serious failures in both the management of and clinical care of vulnerable residents, who you exposed to a risk of harm.

Mr Kennedy referred the NMC guidance SAN-2a and SAN-2b and submitted that taking no further action or a caution order would not be appropriate in view of the public protection issues identified. He submitted that these options would also be insufficient to maintain public confidence in the profession.

Mr Kennedy referred to NMC guidance SAN- 2c and submitted that conditions of practice are appropriate when the concerns can be remediated. He submitted that a number of the concerns in this case are non-clinical and arose from your failings in managing the Home which you owned. He submitted that the concerns were long standing and you did not have systems in place to ensure that staff were properly trained for their roles.

Mr Kennedy submitted that your failings included not ensuring that risk assessments for residents were in place, there was sufficient staff on duty, that safeguarding referrals were made and that suitable professional advice was sought when appropriate. He submitted that in one case a resident was deprived of their liberty without legal authority.

Mr Kennedy submitted that the concerns are so egregious that they would not be addressed by conditions and, accordingly, the imposition of a conditions of practice order would not adequately protect the public or satisfy the wider public interest.

Mr Kennedy referred to NMC guidance SAN-2d and submitted that a suspension may be appropriate in a case where there is no evidence of repetition and no harmful deep seated attitudinal concerns. He submitted that there is no evidence of repetition in this case, however, the panel has found there to be some attitudinal issues and a lack of insight, which points to a removal from the register on a permanent basis.

Mr Kennedy referred to NMC guidance SAN-2e which provides that if the actions of the professional are fundamentally incompatible with being a registered nurse, they should be permanently removed from the register.

Mr Kennedy submitted that you have had a number of years to reflect on what went wrong at the Home, but you are still reluctant to accept your shortcomings, and you have not commented on how you would address them in the future. He submitted that the panel found that you remain of the view that a high standard of care was provided at the Home. Mr Kennedy submitted that a striking off order is required, however, it is a matter for the panel.

Ms Hartley submitted that you have dedicated your life to nursing having commenced your training in 1974 and qualifying as a state enrolled nurse in 1976. She submitted that you spent 22 years gaining experience working in hospitals and in the community, gaining experience in psychiatric nursing, you started your own business in 1997, and the Home was started in 2007.

Ms Hartley submitted that even while running the business you continued to work as a nurse, which is your true vocation.

Ms Hartley submitted that you have been on an interim suspension order since August 2022, but you are incredibly motivated to return to practice with whichever safeguards the panel sees fit.

Ms Hartley submitted that you have engaged with these lengthy proceedings. She submitted that you made a number of admissions and many of the charges were not found proved.

Ms Hartley submitted that you accept that things have gone wrong. She submitted that the panel should consider your early apologies and admissions along with your developing insight into your misconduct.

Ms Hartley submitted that you have had a lengthy and previously unblemished career as a registered nurse.

Ms Hartley submitted that the panel should consider a conditions of practice order with stringent conditions which would allow you to work towards returning to practice unrestricted.

Ms Hartley suggested that potential conditions may include: a condition preventing you from undertaking managerial or oversight responsibilities over a nursing or care home, indirect supervision, a personal development plan to address the weaknesses identified in relation to safeguarding and the deprivation of liberty standards. She submitted that you have undertaken much training now and would like to put this into practice, as you would like the opportunity to work in frontline nursing.

Ms Hartley submitted that the majority of the charges are related to your oversight role, which is covered by the first proposed condition.

Ms Hartley submitted that the incidents occurred during a very challenging and intense period for nursing and care homes who were keeping vulnerable people safe from the COVID-19 pandemic. She submitted that this is not an excuse but an explanation.

Ms Hartley submitted that many of the charges relate to your failings in your oversight of the Home. She submitted that you were not present for either inspection and the inspectors only spoke to Colleague 2. She submitted that this was a time of strain on you as you were travelling back to and from the United States to [PRIVATE], consequently, you were not around as much as you should have been.

Ms Hartley submitted that it was a group decision along with the nurse to admit Resident A and you agreed to this in good faith, believing that they were qualified. She submitted that you did not consider the impact that the admission of this resident would have on the dynamic of the Home. She submitted that your intentions were kind but some of the methods used were outdated and not person centred.

Ms Hartley submitted that staff knew each other and residents very well in the close knit and small Home.

Ms Hartley submitted that you accept you were more reactive than proactive, however, when issues were brought to your attention you remedied them. She submitted that following the CQC inspection all staff were provided with further training, up to date infection control training was undertaken, there were extensive improvements in food hygiene, a new management structure was imposed and new auditing systems put in place.

Ms Hartley submitted that you have no intention to work in management or in an oversight role in the future.

Ms Hartley submitted that the panel found that the misconduct in this case is remediable and that your reflection is developing. She submitted that you have completed a significant number of courses, but you have not been able to strengthen your practice. She submitted that a conditions of practice order would allow you to put your theoretical training into practice, the public would be protected, and you would be supervised whilst having areas identified for development.

Ms Hartley submitted that the panel should consider that you are nearing the end of your working life and that conditions would protect the public, address the public interest whilst considering your interests. She submitted that your 50 year previously unblemished career means everything to you.

Ms Hartley submitted that the panel should reread your testimonials which describe you as a '*kind and caring professional'* and an '*asset to the profession'.*

Ms Hartley submitted that you have completed some further training in the intervening period since October.

Ms Hartley submitted that conditions of practice are the proportionate step to address all of the considerations in this case.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

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

The panel took into account the following aggravating features:

- You are a very experienced nurse who was in a leadership role at the Home. You had full oversight responsibilities as the registered provider and nominated individual at the Home.
- A pattern of misconduct over a period of time, which included poor risk assessments, inadequate health and safety protocols, poor safeguarding for residents and a lack of training for staff.
- Vulnerable patients were exposed to a serious risk of harm
- You were at the meeting when restrictions were placed on Resident A and despite the knowledge that she had full capacity you allowed her to be coerced into signing a care plan approach. This constituted an abuse of a position of trust as you were the registered provider and nominated individual at the Home.
- The decision to take on residents whilst there were staff shortages at the Home increased the existing risks that were apparent.
- Limited insight into failures.

The panel also took into account the following mitigating features:

- Immediate steps were taken to rectify some issues identified by the CQC inspection.
- Some acceptance of your role in failures and some apologies.

- A number of admissions were made at the start of the proceedings.
- The events occurred during the COVID-19 pandemic when there was a lot of stress in the system.
- Your challenging personal circumstances in terms of your responsibilities in caring for [PRIVATE] abroad.
- Training undertaken to strengthen your practice as a registered nurse.

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.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict your practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to the NMC Guidance on *'Conditions of practice order'* (Reference: SAN-2c Last Updated: 28/01/2026) and had regard to the following factors:

- *‘no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional’s practice in need of assessment and/or retraining*
- *competence cases where there is a realistic likelihood that the concerns about their practice can be resolved*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *insight into any health problems, alongside willingness to abide by conditions relating to a medical condition, treatment and supervision*
- *people using services will not be put at risk either directly or indirectly as a result of the conditions*
- *conditions can be created that can be monitored and assessed.’*

The panel is of the view that there are no proportionate conditions that could be formulated, given the serious misconduct identified in this case.

The panel considered that you had oversight responsibilities at the Home and you should have identified and rectified the issues before the CQC inspection. You deferred your responsibilities to another member of staff and, as a result of this, there was a risk of serious harm to patients. The panel decided that the placing of conditions on your registration would not adequately address the seriousness of this case or the public protection or public interest concerns, due to the wide ranging and serious failures in this case, your attitudinal concerns that were exposed during the hearing and your limited insight and developing reflections.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *‘Suspension order’* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *‘the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.’*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

The panel was satisfied that in this case, the misconduct was not sufficiently serious to be fundamentally incompatible with you remaining on the register. It decided that a temporary removal from the register would give you time to reflect, feed back to a reviewing panel, protect the public and give you the opportunity to do some further training, reflections and improve your insight, prior to returning to unrestricted practice in the future, should you choose to do so.

The panel considered that you are a very experienced nurse with a long-standing unblemished career up until the CQC inspection. The panel accepted that a number of concerns have been rectified since the inspection and there is a realistic prospect that you can gain insight and strengthen your practice during a period of suspension.

The panel went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

In making this decision, the panel carefully considered the submissions of Mr Kennedy in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a striking off order is not proportionate in this case. Whilst there were failings over a period of time, once identified, systems were put in place to rectify some of these failings. The panel decided that the public would be protected, and public confidence would be maintained by a temporary removal from the register.

The panel determined that a suspension order for a period of 6 months was appropriate in this case to mark the seriousness of the misconduct. In making this decision the panel made reference to *Kamberova v Nursing and Midwifery Council [2016]* EWHC 2955 (Admin) and considered that you have been subject to an interim suspension order since August 2022.

At 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:

- Evidence of insight into failings, particularly how you would do things differently in the future under any challenging circumstances;
- A personal development plan to evidence further strengthened practice in relation to:
    - Safeguarding,
    - Risk assessments, in relation to identifying the needs of patients/resident
    - The Mental Capacity Act including Deprivation of Liberty Safeguards
    - Understanding the need to involve a multi disciplinary team approach
- Evidence of leadership, management and governance training

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that an 18 month interim suspension order is necessary as if the substantive order is to be appealed, it will not come into force until the appeal is decided. In this case, if there were no interim order you would be able to practice without restriction. He submitted that this would mean that the public would not be protected and the public interest would not be satisfied in the way that that panel found necessary.

The panel also took into account of the submissions made by Ms Hartley. She submitted that the application is not opposed.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period.

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

This will be confirmed to you in writing.

That concludes this determination.