Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday 17 July 2024 – Friday 19 July 2024

Virtual Meeting

Name of Registrant:	**Anne Elizabeth Winstanley**
NMC PIN	81I4135E
Part(s) of the register:	Registered Nurse – Sub Part 1 Learning Disabilities Nursing – (November 1985)
Relevant Location:	Cheshire East and Gwynedd
Type of case:	Misconduct
Panel members:	Deborah Jones (Chair, Lay member) Carol Porteous (Registrant member) Alex Forsyth (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Charis Benefo
Facts proved:	Charge 1
Facts not proved:	Charges 2a, 2b, 2c, 2d)i, 2d)ii, 2d)iii, 2d)iv, 2e, 2f and 2g
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Ms Winstanley's registered email address by secure email on 23 May 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation. It also advised Ms Winstanley that a panel of the Fitness to Practise Committee at a Notice of Referral Meeting on 2 May 2024 had decided to refer this matter to a substantive meeting. The Notice of Meeting indicated that the substantive meeting would be held virtually on or after 2 July 2024.

In the light of all of the information available, the panel was satisfied that Ms Winstanley has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse,

1. While employed as registered manager at Greengables Nursing Home, did not properly record and/ or report a safeguarding incident for Resident IH.

2. While employed as registered manager at Bay Nursing Home ("the home"),
    a. Did not ensure staff were adequately trained.
    b. Left residents without appropriate assistance at mealtimes.
    c. Did not ensure there were sufficient members of staff on duty.
    d. In relation to Resident A, did not:
        i. Make a referral to the district nursing team.
        ii. Arrange for a pressure releasing mattress to be provided.
        iii. Seek medical advice.
        iv. Document required notifications/ changes.

e. Did not make timely third party referrals.
f. Did not properly assess residents needs prior to admission to the home.
g. In relation to Resident C, did not put a care plan in place for manual handling.

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

Background

Ms Winstanley was referred to the NMC on 8 October 2020. She entered the NMC register on 19 November 1985.

At the time of the concerns in relation to charge 1, Ms Winstanley was the Registered Manager of Greengables Nursing Home (Greengables). Ms Winstanley joined Greengables on 1 September 2016 as a nurse and progressed to Deputy Manager in March 2017 before being promoted to Manager on 26 November 2018.

During morning handover on 21 May 2020, Resident IH, who suffered from Parkinson's disease, was reported to be particularly unwell. Staff were advised that he was to be nursed in bed all day. Later the same morning, Resident IH was reported to be uncomfortable and required repositioning. Witness 3, a healthcare assistant at Greengables, assisted Resident IH with his pillows and went to make his breakfast.

Upon Witness 3's return, Resident IH was found sitting in his recliner chair, in a distressed state. He asked Witness 3 to "*get this animal out of my room*", referring to an agency healthcare assistant, Colleague A. Resident IH told Witness 3 that Colleague A had picked him up in a bear hug to put him on the commode and then wheeled him across the room on the commode. She then picked him up again and seated him in his recliner. Colleague A had hurt Resident IH's legs in the process.

Witness 3 reported the incident to a nurse, Witness 2, who in turn reported it to Ms Winstanley who reportedly responded with "*oh no, not a-bloody-gain*". Ms Winstanley reportedly said this was Resident IH's second complaint in a matter of months and that

she would deal with it. Witness 2 assumed this to mean Ms Winstanley would report the matter.

On 28 May 2020, Witness 5, Area Quality Manager of Greengables, was in the office when Ms Winstanley received a call from the Care Quality Commission (CQC). The call concerned a "*whistleblower*" referral about an unreported incident whereby a resident was handled roughly. Witness 5 recalled Ms Winstanley saying she had been aware of the incident at the time it happened but she was allegedly unable to evidence any of the correct steps that should have been completed.

Witness 5 instructed Ms Winstanley to follow safeguarding procedure and set out what should be done before she left for the day in the belief that Ms Winstanley would follow the necessary steps.

Witness 5 was at Greengables again on 2 June 2020 with Witness 4, Quality Regulation Manager for HC-One, who was conducting an inspection. Witness 5 and Witness 4 were made aware that Ms Winstanley had not dealt with the safeguarding incident at all.

Ms Winstanley subsequently left Greengables.

Further concerns

During the NMC's investigation, a request for an employment reference from Ms Winstanley's employer, Bay Nursing Home (the Home), was made. This revealed further alleged concerns with Ms Winstanley's practice.

Ms Winstanley was employed as the Registered Manager of the Home from 14 September 2020 until 13 August 2021.

Witness 6, Inspector for the Care Inspectorate Wales (CIW), conducted an inspection of the Home on 21 June 2021. The following concerns with staff training were identified: (1) out of 31 members of staff, 29 had not received training in Deprivation of Liberty Safeguards and (2) there was a lack of training in diabetes despite some residents having a diagnosis of diabetes.

Witness 6 reviewed the staff rota of the Home for a three-week period and noted that it was short staffed on all of the 21 days reviewed.

Witness 6 also reviewed a safeguarding referral for Resident B, made by an Occupational Therapist (OT) who visited the Home on 25 May 2021 and 1 June 2021. On both occasions the OT found Resident B with a meal in front of them, untouched, with no assistance and the call bell was out of reach. The OT raised concerns with staff on the first occasion but found Resident B in the same situation a week later.

Witness 6 found a further safeguarding concern relating to Resident A who developed additional pressure sores. It is alleged that this was as a result of not receiving timely intervention, being cared for on a normal mattress rather than a pressure releasing mattress, not seeking medical advice and a failure to escalate their care to the district nurses. Ms Winstanley had also allegedly failed to document the required notifications and changes such as when Resident A was discharged from hospital and when Resident A arrived back at the home.

Witness 6 discovered that Ms Winstanley had allegedly failed to properly assess the needs of residents prior to admitting them to the Home. In relation to Resident C, Ms Winstanley allegedly failed to ensure a plan was put in place regarding manual handling, which meant staff had no information on how to move the resident safely.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: An Area Director at HC-One Care (HC-One);
- Witness 2: Registered General Nurse at Greengables Nursing Home at the time of the concerns;
- Witness 3: Healthcare Assistant at Greengables Nursing Home at the time of the concerns;
- Witness 4: Quality Regulation Manager at HC-One;
- Witness 5: An Area Quality Director at HC-One; and
- Witness 6: An Inspector for the CIW.

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

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

Charge 1

That you, a registered nurse,

1. *While employed as registered manager at Greengables Nursing Home, did not properly record and/ or report a safeguarding incident for Resident IH.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Witness 2. Witness 3, Witness 4 and Witness 5 in respect of this charge.

In particular, the panel noted Witness 4's written statement dated 23 February 2022 which stated:

> '*... at the very least, I would have expected the Nurse to report this to the local safeguarding team. The local safeguarding team is an external body that would review the allegation, request information, and investigate (if necessary) or confirm that they were satisfied with the actions that had been taken. It is an important part of working in healthcare with vulnerable people, as it ensures every harm potentially caused to a vulnerable person is taken seriously, investigated and appropriate actions taken, which helps shape safer practices and protects vulnerable people.*
>
> *This is what I would have expected at a minimum. The Nurse should have also reported this to CQC, completed an investigation, recorded the allegation and investigation in the nursing notes and recorded this on our internal Datix system which would alert the directors of this incident. ... Safeguarding and reporting have always been necessary priorities for the healthcare industry and therefore I do not have any idea how the Nurse may not have known this. I have no idea why they would not have reported this incident in the correct way.*'

The panel also noted Witness 5's written statement dated 23 March 2022 which stated:

> '*...I would have then expected the Nurse to complete an incident form, like we had practiced on numerous occasions. Then upload that to Datix. The Nurse should have then completed a safeguarding report to the local authority, detailing their actions to investigate in full, and also should have completed a CQC notification and submitted that. There is a specific notification for CQC allegations of abuse that would have been appropriate here. The Nurse would have been aware to follow these steps, ensuring the Datix, Local Authority safeguarding report and CQC notification were completed from their training in safeguarding, and also from the*

one to one tuition the Nurse received from myself. The Nurse was fully conversant in safeguarding procedures, policies and steps to be taken.'

The panel had sight of the HC-One Safeguarding Policy.

The panel took into account Witness 3's written statement dated 2 April 2022 where she stated that after being informed by Resident IH of the incident involving Colleague A, she reported it to Witness 2. In her written statement, Witness 3 stated that she trusted Witness 2 to report the matter to Ms Winstanley

Witness 2, in her written statement dated 24 January 2022, confirmed that she told Ms Winstanley about the incident involving Resident IH and Colleague A. Witness 2 stated that:

'*The Nurse appeared cross and frustrated at the situation, saying something akin to "and that poor nurse he accused probably won't be able to work again" regarding the previous incident. I cannot recall the exact words the Nurse used, but they seemed irritated by my news, and the incident that occurred a few months ago. I explained again that Resident IH seemed incredibly agitated and upset, and was accusing [Colleague A] about being very rough with them and did not want to see [Colleague A] again.*

The Nurse said "yes, yes, leave it with me, I will deal with it." They seemed quite stressed so I offered to help them, but they declined and said that they would deal with it. I left the office and continued with my shift and did not hear anything else about this until the investigation began.'

There was no documentary evidence before the panel that the safeguarding incident involving Resident IH was properly recorded and/or reported. It noted that Ms Winstanley had admitted that she did not follow the correct procedure during the local investigation.

The panel then had regard to Ms Winstanley's reflection dated 26 September 2021 which stated:

'...
I didn't report to safeguarding ? why not ? because at the time myself and the nurse had dealt with it , the family had been informed , the gentleman was fine , the agency care worker had been spoken to by the nurse. As a manager you make day to day decisions , this is what I did . nobody was hurt

It was a week later when I received a phone call from cqc to say that somebody had reported this,saying that they didn't think I had dealt with the incident and did I know anything about it , I explained what had happened and he advised me to contact safeguarding which I did .

Im not shy of reporting anything if I think it needs reporting I will do it ...[sic]'

The panel was satisfied that Ms Winstanley had been under a duty to record and report this incident. It considered that Ms Winstanley's reflection in respect of this allegation amounted to an admission that she did not properly record and/or report the safeguarding issue involving Resident IH.

The panel therefore found charge 1 proved.

Charge 2

In relation to charge 2 in its entirety, the panel considered that based on the documentary evidence before it, there were various longstanding concerns with the Home, including staffing issues, before Ms Winstanley took over as Home Manager.

The panel also noted that Ms Winstanley's alleged omissions took place during the COVID-19 pandemic, where there were issues around staffing, the availability of suitable training and the opportunity for staff to carry out training.

The panel noted that the only evidence in relation to this charge was from Witness 6 and comprised of her NMC written statement and a number of exhibits relating to her inspection of the Home and subsequent meetings. The panel received no documentary evidence from the Home such as Ms Winstanley's job description; the Home's policies and

procedures; residents' notes; statements from the Home's Responsible Individual (Colleague B) or the Occupational Therapist; statements from any other members of staff; and staff rotas. The panel noted that some of the heads of charge related to matters which occurred over one or two specific days and the panel had been provided with no evidence as to whether Ms Winstanley was in fact on duty on those days.

Charge 2a

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
    a. *Did not ensure staff were adequately trained.*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's written statement dated 30 September 2022 which stated:

> '*I recall, upon receiving the documents regarding staffing and training, that the Home appeared to have failed to make any significant improvements in the areas identified in the last inspection with regards to staff training. I thought this after reviewing a copy of the Home's staff training matrix (which was provided at the inspection site, but CIW did not retain a copy of this on our systems for the reasons mentioned above). From memory, I recall my concerns were around staff lacking training, with particular reference to catheter care and safeguarding. As mentioned in my inspection report, 26 staff had not received dementia awareness training, and 29 staff had not received Deprivation of Liberty Safeguards training, out of a total of 31 staff on the training matrix. An AFI was issued to the Provider during the inspection in October 2020, as detailed above, which clearly set out the failure regarding the staff training. It is expected that the Provider should have made the necessary improvements by the next inspection.*'

The panel noted that Witness 6 had identified these failings during her inspection of the Home on 21 June 2021. Witness 6 had also pointed out that similar failings had been identified at the previous inspection in October 2020 when Ms Winstanley had only been in

her post as Home Manager for around one month. The panel noted from Witness 6's evidence that the issues around staff training had not been rectified between October 2020 and June 2021.

In addition, the panel noted Witness 6's written statement evidence that:

> '*... The Responsible Individual, [Colleague B], had overall responsibility for ensuring staff training was up to date, by having oversight over the training records for staff at the Home. The Nurse's exact responsibilities regarding staff training would depend on what was set out in their job description, but I would expect a Manager of a Care Home to ensure staff had all necessary training in place.*
> *...*
> *The Responsible Individual, [Colleague B], has overall responsibility to ensure staff in the Home have a range of skills and qualifications to meet the needs of the people using the service. The Nurse, as the manager of the Home, is responsible for ensuring training is sourced and staff complete the relevant training. There is an overarching duty in regulation 34 (1) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 ("RISCA") that the provider ensures suitable staffing at the Home. The Nurse should have been aware of the regulations and their duties to uphold this overarching regulation from their job description. Failing to ensure staff are appropriately trained places the residents of the Home at risk that their care needs will not be met.*
>
> *I discussed the inspection with the Responsible Individual, [Colleague B] during a telephone call shortly after the inspection, and I recall [Colleague B] saying they would look into the concerns. I did not keep a record of this conversation.*
> *...*
> *The notice is issued to the service provider... In summary,... the concerns were that:*
> *...*
> *d) staff were not appropriately trained.'*

It was clear from the evidence that there were longstanding issues at the Home with staff training. Based on the evidence before it, the panel determined that the responsibility to ensure that staff at the Home were adequately trained lay with Colleague B as the

Responsible Individual/Service Provider. Any responsibility for such issues which was delegated to the Home Manager would have been set out in the job description. Given that no such job description was provided to the panel, and in the absence of any evidence from Colleague B or any other staff member from the Home, the panel could not be satisfied that Ms Winstanley was responsible for staff training.

There was also no evidence as to whether or not Ms Winstanley had raised concerns about staff training to Colleague B.

The panel therefore found charge 2a not proved.

Charge 2b

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
    b. *Left residents without appropriate assistance at mealtimes.*

This charge is found NOT proved.

In reaching this decision, the panel noted that the evidence before it related to Resident B.

The panel took into account Witness 6's written statement dated 30 September 2022 which stated:

> *'From the documents I had requested following the physical inspection, I received copies of a safeguarding referral for a resident, Resident B, from an Occupational Therapist... who had visited the Home on 25 May 2021 and 1 June 2021. On both occasions [Occupational Therapist] had found Resident B with their meal left in front of them untouched, as they had had no assistance for their meal, and their call bell was unreachable.'*

The panel accepted the evidence that Resident B was left without appropriate assistance at mealtimes. It noted that there was no evidence before it to suggest that Ms Winstanley worked in a nursing capacity at the Home. The panel was of the view that it would have

been the responsibility of the nurse in charge and the nursing staff who were caring for Resident B to ensure that adequate care was being provided, including appropriate assistance at mealtimes. The panel had no evidence of who the nurses working on shift were when the Occupational Therapist visited the Home.

The panel had sight of the minutes of the Adult Protection Strategy Meeting held on 28 June 2021 which indicated that Resident B was a gentleman with variable needs which meant that on some occasions he could feed himself and on other occasions he could not. The minutes stated that staff were not dealing with Resident B's variable needs and that this may have related back to their lack of training.

Given its findings at charge 2a, the panel could not be satisfied that Ms Winstanley was responsible for this lack of training.

In all the circumstances, the panel was not satisfied that Ms Winstanley had a direct responsibility to provide residents with appropriate assistance at mealtimes. It therefore found charge 2b not proved.

Charge 2c

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
    c. *Did not ensure there were sufficient members of staff on duty.*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's written statement dated 30 September 2022, which stated:

> '*The Responsible Individual, [Colleague B], had overall responsibility for ensuring the staffing at the Home was adequate, and the Nurse, as Registered Manager, had responsibility for monitoring staffing levels, or issues, arising from sickness or annual leave. The Nurse would be aware of their responsibilities regarding staffing levels at the Home, as this should be set out in their job description. Furthermore,*

as the Home Manager the Nurse would be aware of their overall responsibility to ensure the smooth day to day running of the Home, which includes ensuring correct staffing.

If there were issues with short staffing, then the Nurse should have contacted the Responsible individual [Colleague B] to discuss arrangements to cover the deficit in the care shifts such as contacting care agencies.

...

The notice is issued to the service provider... In summary,... the concerns were that:

...

c) there was not always a sufficient number of suitably qualified staff to work at the service;...'

The panel had no evidence before it as to what the staffing levels were at the time, or what the expected levels should have been at the Home. As in previous charges, the panel was not provided the job description which would have clarified the responsibilities delegated by Colleague B to Ms Winstanley in relation to staffing levels. There was also no evidence as to whether or not Ms Winstanley raised issues about short-staffing with Colleague B.

The panel noted the minutes of the Adult Protection Strategy Meeting held on 8 September 2021 which stated that:

'*[Consultant C] shared that she's had a look at documentation, including the minutes of the strategy meeting on 28/06/21, there are a few comments made in the minutes that it would be good to have clarity, and further explanation on. One of the things that was mentioned was that the home was understaffed, [Consultant C] has had a look at the rosters on the dates mentioned and the home was staffed appropriately. [Consultant C] wanted to understand what the definition of under staffed is and what are the expectations in terms of staffing levels in relation to the number of residents, there is a diverse mix of residents in the home some are independent and some are not. There are 16 residents needing residential care support and 11 residents requiring nursing support. What exactly does appropriate staffing look like?*'

Consultant C was an Independent Consultant working with the Home.

The panel considered that there was conflicting evidence as to whether the Home had sufficient members of staff on duty.

The panel could not be satisfied that Ms Winstanley was under a duty to ensure that there were sufficient members of staff on duty, and therefore found charge 2c not proved.

Charge 2d)i

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
    d. *In relation to Resident A, did not:*
        i. *Make a referral to the district nursing team.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence that Resident A returned to the Home from the hospital with pressure sores.

The panel noted Witness 6's written statement dated 30 September 2022, which stated:

> '*It was the nursing staff's responsibility to ensure they informed the district nursing team of the pressure sore and discuss this at the time with the Nurse (in their capacity as the Home's manager). Resident A is a residential client and all their nursing needs fell under the care of the district nurses. Residential clients are residents within the Home whose nursing needs are met exclusively by the district nurses (rather than the nurses employed by the Home). The qualified nurses in the Home should be aware of any residential clients' clinical needs and should be referred straight away to the district nursing team. There should be a policy and procedure in place at the Home to instruct staff on the correct approach, and I recall seeing this policy on a separate inspection, but I did not request a copy of the policy.*
>
> *...*

The notice is issued to the service provider... In summary,... the concerns were that:

...

b) external professionals were not being contacted to inform them of changes to residents needs and/or appropriate referrals were not being made to third parties...'

The panel noted from the minutes of the Adult Protection Strategy Meeting held into the safeguarding concerns regarding Resident A on 8 July 2021:

'*[District Nursing Matron] stated that there were 3 issues that need to be addressed with regards to the safeguarding concerns*

- *Discharge from Bronglais Hospital have they seen the address as being a nursing home and assumed that The Bay has only nursing beds. They need to be having a discussion with the home pre discharge, if this had happened they would have known that she was receiving residential care and would come under the assessment of district nursing team.*

...

[Hospital Senior Manager] stated that Bronglais Hospital accept that they should have made contact with the district nursing team pre discharge and wanted it noted in the minutes. There were circumstances why it didn't happen, the patient was in a bed in a surge area, the nurses are from outside of area, they come in to work on random days, they see the word nursing home and make assumptions. We fully accept that we should make contact an are putting things in place to make sure this won't happen again.

...

[Ms Winstanley] stated that the only thing they have received is a discharge letter informing them that she was to be taken off her pain relief medication.'

It was apparent to the panel that the hospital was responsible for referring Resident A to the district nursing team, because Resident A was under residential care at the Home, and not nursing care. It was clear that due to this being misunderstood, the hospital did not make the referral.

However it was also clear from the timeline of Resident A's care, which was provided by Ms Winstanley for the meeting, that the district nursing team was contacted by the Home, but that they could not see Resident A due to her aggressive behaviour. This was confirmed in the minutes of the Adult Protection Strategy Meeting held on 8 September 2021, where Consultant C referred to the minutes of the previous strategy meeting and clarified some matters:

> '*1. <u>No medical advice being sought</u> – ... [District Nursing Matron] referred back to the request on 25/06/21 for a district nurse to* attend*, [Consultant C] shared that the notes state that they didn't attend because Resident A was too aggressive for them to attend.'*

The panel noted that it had been provided with no evidence as to whether Ms Winstanley was actually working over this period.

Given the contradictory evidence before the panel, this charge is found not proved.

Charge 2d)ii

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
   d. *In relation to Resident A, did not:*
      ii. *Arrange for a pressure releasing mattress to be provided.*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's written statement dated 30 September 2022 which stated

> '*The District Nurse was also concerned to find Resident A, who was at risk of developing pressure sores, being cared for on a normal mattress rather than a pressure releasing mattress which would minimise the risk of developing pressure sores.*
>
> ...

...There was no notification of discharge by Bron Glais Hospital, concerns around the condition of Resident A following discharge. There was no notification of arrival back at the Home, Resident A had apparently been bed bound (according to GP report) for 12 days, and the District Nursing team were not notified in order to provide adequate pressure relieving equipment.'

The minutes of the Adult Protection Strategy Meeting held on 8 July 2021, stated that:

'*Is there an assumption that because it's a nursing home that there are air mattresses on every bed? – [Ms Winstanley] shared that they only tend to put an air mattresses on the bed if they are nursed in bed. Prior to her first admission she was mobilizing independently. If they had known that she was to be nursed in bed they would have changed the mattress to an air mattress.*

[Hospital Senior Manager] was asked whether the hospital checks that the equipment is in place prior to their discharge, he confirmed that they do.

...

[Ms Winstanley] stated that the only thing they have received is a discharge letter informing them that she was to be taken off her pain relief medication.'

The panel noted that, as in charge 2d)i, the strategy meeting identified that there had been confusion at the hospital as to whether Resident A was a nursing care or residential patient. This led to failures in her discharge in that the district nursing team were not informed. It further noted from the minutes of the Adult Protection Strategy Meeting held on 8 September 2021 that the transfer of care letter had not been sent home with Resident A, but had been posted.

On the basis of this evidence, the panel considered that it was the responsibility of the district nursing team to provide adequate pressure relieving equipment for Resident A. However, due to the misunderstanding, Resident A was not referred by the hospital to the district nursing team and therefore this was not done.

The panel therefore found charge 2d)ii not proved.

Charge 2d)iii

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
   d. *In relation to Resident A, did not:*
      iii. *Seek medical advice.*

This charge is found NOT proved.

In reaching this decision, the panel took into account the minutes of the Adult Protection Strategy Meeting held on 8 September 2021, where Consultant C referred to the minutes of the previous strategy meeting and clarified some matters:

> '*1. <u>No medical advice being sought</u> – [Consultant C] referred to "no medical advice being sought", but having looked at the home's notes and emails, they contacted the GPs 4 times during the period Resident A had been readmitted to The Bay. They contacted the district nursing team twice, 25/06/21 and the day of her readmission to Bronglais Hospital. [District Nursing Matron] referred back to the request on 25/06/21 for a district nurse to attend, [Consultant C] shared that the notes state that they didn't attend because Resident A was too aggressive for them to attend. [District Nursing Matron] reported that she would look into it and asked whether it was documented how the district nurses had been contacted. [Consultant C] agreed to look into it and report back. In relation to pain relief, The Bay contacted Tywyn Health Centre on 21/06/21 to discuss the changes to pain relief. During Resident A's time in Bronglais Hospital they had stopped it all, the patches and the co-codamol and replaced it with paracetamol.*
> *According to [Consultant C] the hospital's notes clearly stated that she was in pain on the day of discharge. A discussion was had with the GP on 23/06/21 and 28/06/21 and it [sic] only on 29/06/21 that the pain relief patches were reinstated followed by the co-codamol, thus taking the medication back to what it was prior to admission.*'

The panel was satisfied on the evidence before it that the General Practitioner (GP) was, in fact, contacted for medical advice. It therefore found this charge not proved.

Charge 2d)iv

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
    d. *In relation to Resident A, did not:*
        iv. *Document required notifications/ changes.*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's written statement dated 30 September 2022 which stated:

> '*It is the nursing team's responsibility to inform the District Nurses of Resident A's return to the Home, and to conduct an assessment of Resident A's current care needs. The nursing staff should have been aware of which residents were residential clients, and what information that they needed to provide the district nurses with, from the policy and procedure (as referenced above).*'

The panel did not have sight of Resident A's records, so there was no evidence before it as to whether anything was documented or not by the nurses at the Home.

In the minutes of the Adult Protection Strategy Meeting held on 8 July 2021, Ms Winstanley was asked to provide a timeline between 18 June 2021 when Resident A was re-admitted to the Home and 30 June 2021 when she returned to hospital. The panel considered that Ms Winstanley's timeline provided a clear chronology of what happened on each day, including the GP and district nursing team being contacted and changes in Resident A's condition being recorded. In the panel's view, this suggested that there was documentation of required notifications/changes.

The panel therefore found this charge not proved.

Charge 2e

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
   e. *Did not make timely third party referrals.*

This charge is found NOT proved.

In reaching this decision, the panel noted that the charge did not particularise which third parties were being referred to. However, it took into account Witness 6's written statement dated 30 September 2022, which made reference to Deprivation of Liberty Safeguards (DoLS) referrals not being made.

Witness 6's written statement evidence was that:

> '*Concerns regarding external professionals not being contacted to inform them of changes to residents needs and/or appropriate referrals were not being made to third parties...*
>
> *In summary, the Nurse had failed to notify CIW of the implementation of a DoLS application or follow the correct procedure in obtaining the DoLS application.*
> *...*
> *My concerns from this observation were that there was no evidence of a multidisciplinary meeting to discuss the implementation of the DoLS, nor was there evidence to show the Nurse had sought advice from the Local Authority for the use of the stair gate. Furthermore, CIW had not received any notification for the implementation of the DoLS. This should have been reported to the CIW by the Nurse as per Regulation 60 under the Regulated Services (Service Provider and Responsible Individuals) (Wales) Regulations 2017. In particular;*
>
> *i. Regulation 60 (1), which stipulates the service provider must notify the service regulator of the events specified in parts 1 and 2 of Schedule 3;*
> *and*

ii. Part 1; notifications to the service regulator in respect of all service, (22) any requests to a supervisory body in relation to the application of DoLS.'

Witness 6's evidence was that the Regulations state that it is the responsibility of the Service Provider (Colleague B) to make DoLS referrals. Witness 6 appeared to make the assumption that this would have been delegated to the Home Manager. However, as previously noted, the panel did not have sight of a job description detailing delegation of this task to Ms Winstanley, nor any evidence from Colleague B or any other staff at the Home. The panel therefore could not find that it was Ms Winstanley's responsibility to make DoLS referrals.

The panel therefore found charge 2e not proved.

Charge 2f

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
   f. *Did not properly assess residents needs prior to admission to the home.*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's written statement dated 30 September 2022 which stated:

'*The concern was that Resident C had not been out of bed for over three weeks since they were admitted to the Home. Resident C's family member had informed the Local Authority (who in turn told me) that prior to being admitted to the Home, Resident C was sat up in a chair every day in hospital. There was an issue in obtaining a personal plan for the use of a hoist in order to ensure staff could safely transfer Resident C, The Nurse, in their capacity as the Home's manager, had failed to properly assess Resident C's needs prior to them being admitted to the Home and therefore increased the risk of Resident C's risk of developing pressure damage. It is a regulatory requirement that new admissions, or residents returning from hospital, are reassessed. [Colleague B], as the Responsible Individual, is*

responsible for being aware of these requirements, and ensuring the Home's staff are following the requirements.'

The panel noted Witness 6's assertion that Ms Winstanley had failed in her responsibility to properly assess Resident C's needs prior to admission to the Home. However, the panel did not have sight of Ms Winstanley's job description, or any policy document to demonstrate the procedure at the Home for admitting residents or Ms Winstanley's specific role as manager in this process. The panel could not therefore be satisfied that it was Ms Winstanley's responsibility to assess Resident C's needs prior to his admission at the Home.

On this basis, the panel found charge 2f not proved

Charge 2g

That you, a registered nurse,

2. *While employed as registered manager at Bay Nursing Home ("the home"),*
   g. *In relation to Resident C, did not put a care plan in place for manual handling.*

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 6's written statement dated 30 September 2022 which stated:

'...*There was an issue in obtaining a personal plan for the use of a hoist in order to ensure staff could safely transfer Resident C...*

This incident was serious, in so far as, the Nurse had failed to ensure the care plan was in place regarding manual handling for Resident C, which means there is no information to instruct staff on how to safely move Resident C. In this instance, this resulted in Resident C remaining in bed for a long period of time (three weeks). This information should have been in place prior to Resident C moving into the Home.'

The panel noted that Witness 6 did not specify the nature of the '*issue'* in obtaining a personal plan for the use of a hoist for Resident C.

The panel did not have sight of Ms Winstanley's job description, or any information as to who was responsible for producing care plans at the Home. In addition, the panel was not provided with a manual handling policy, records for Resident C, or any evidence about care plans at the Home and what was to be included in them. The panel considered that care plans would normally be the responsibility of clinical nursing teams, and it had no evidence that Ms Winstanley, as Home Manager, was directly involved in such clinical matters.

The panel then took into account the '*CIW Inspection Report on The Bay Nursing Home*' from Witness 6's inspection on 21 June 2021. It noted that there was no reference in this report to the allegation relating to Resident C. In fact, the report stated that:

> '*Care records seen were detailed and reviewed regularly. Risk assessments have been completed such as moving and handling and bed rails.*'

The panel therefore found that there was insufficient evidence to find this charge 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 Ms Winstanley's 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, recognised the NMC's 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, Ms Winstanley's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The panel had regard to the following written submissions on misconduct contained within the NMC's Statement of Case:

> '*20. Whilst a matter for the panel's professional judgment, the NMC submits that the Registrant's failings are so serious, that they amount to misconduct.*
>
> *21. The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:*
>
> *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.*
> *22. As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), respectively*
>
> *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'.*
> *And*
> *'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.*

23. Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct.

<u>The NMC Code</u>

24. The 10 October 2018 Code was in effect when the incidents occurred.

25. The NMC considers the following provisions of the Code have been breached:

- *1 Treat people as individuals and uphold their dignity.*
  - *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.*
  - *1.5 respect and uphold people's human rights.*

- *8 Work co-operatively.*
- *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate.*
- *8.2 maintain effective communication with colleagues.*

- *10 Keep clear and accurate records relevant to your practice.*
  - *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime 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.*

- *16 Act without delay if you believe that there is a risk to patient safety or public protection.*
- *16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our*

guidance and your local working practices.

- *17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection.*
- *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.*
- *19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.*
- *20 Uphold the reputation of your profession at all times.*
- *20.1 keep to and uphold the standards and values set out in the Code.*

26. It is submitted that the breaches of the Code amount to misconduct and are serious. Misconduct, especially whilst in a managerial nursing position, puts patients at risk. The Registrant's failure to ensure that there were sufficient members of staff on duty and that staff who were working were adequately trained, also placed residents at risk of harm.

27. The Registrant's failure to report a safeguarding incident and not making timely third-party referrals, gives rise to public protections concerns. Patients were placed at a real risk of harm as a result of these failures.

28. The Registrant's shortfall in basic areas of nursing such as record keeping, seeking medical advice, ensuring appropriate care plans are in place, making arrangements for residents to have assistance at mealtimes and ensuring residents have the correct pressure equipment, fell so far below the standards expected from a registered nurse that they amount to misconduct.

29. The public interest is engaged as the Registrants misconduct has the potential to damage public confidence in the profession.'

The NMC requires the panel to bear in mind the overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC, in its written Statement of Case, invited the panel to consider the following in respect of impairment:

> *'30. The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. The question that will help decide whether a professional's fitness to practise is impaired is:*
>
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
>
> *31. If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.*
>
> *32. Answering this question involves a consideration of both the nature of the concern and the public interest. In addition to the following submissions the panel is invited to consider carefully the NMC's guidance on impairment.*
>
> *33. When determining whether the Registrant's fitness to practise is impaired, the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) are instructive. Those questions were:*
>
> *1. has the Registrant in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or*
> *2. has the Registrant in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or*

3. has the Registrant in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or
4. has the Registrant in the past acted dishonestly and/or is liable to act dishonestly in the future.

34. It is the submission of the NMC that points 1, 2 and 3 can be answered in the affirmative in this case.

i. The Registrant's actions placed residents at risk of harm. Similar actions in the future could lead to a further risk of harm and distress if not addressed.
ii. Nurses occupy a position of privilege and trust, especially when in a managerial role, and are expected to be professional at all times. Patients, their families, and colleagues must be able to trust nurses who must make sure that their conduct justifies both their patients' and the public's trust in the profession, at all times. The Registrant's actions relate to basic and fundamental nursing duties and behaviour, such as documenting safeguarding incidents, seeking medical advice, etc. As such, the Registrant's actions are liable to bring the profession into disrepute.
iii. The Registrant has breached the fundamental tenets of the profession by not providing safe and effective care to patients.

35. Impairment is a forward-thinking exercise which looks at the risk the Registrant's practice poses in the future. NMC guidance adopts the approach of Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

36. The Registrant initially engaged with the NMC and provided a reflective statement on 26 September 2021 in which she referred to the incident with resident IH stating she does not feel she got adequate support but feels deep regret about what happened.

37. Since March 2022, the Registrant has disengaged from the NMC. She was initially represented by the RCN but on 27 March 2024 correspondence was received from the RCN, which stated:

Please find attached our notice to come off record for Anne Winstanley.

Please note that our member has instructed she will not correspond with the NMC and does not intend to attend the hearing.

38. The Registrant has not taken any action to demonstrate remorse or insight to allay the concerns that the conduct would not be repeated. Whilst reflection and training may not fully remediate the situation, it can provide evidence of remorse and willingness to remedy the concerns, which the panel can then use to assess risk and impairment. In this case, there has been no evidence put forward by the Registrant. Therefore, the concerns remain, and the panel are left with limited information to assess impairment.

39. The NMC note that the Registrant has not worked since the concerns were raised. As such, a risk of repetition remains.

40. The NMC consider there is a continuing risk to the public due to the Registrant's lack of full insight and failure to undertake relevant training. She has not been able to demonstrate strengthened practice through work in a relevant area.

Public interest:

41. In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:

"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."

42. Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.

43. In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which hasn't been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.

44. However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.

45. The NMC consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behavior. The Registrant's conduct engages the public interest because the public would be shocked to hear of a registered professional making shortfalls such as the ones the Registrant has made. The public rightly expects nurses to always perform their duties safely and behave in a professional manner. The absence of a finding of impairment risks undermining public confidence in the profession.'

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, *R (On the application of Remedy UK) v GMC* [2010] EWHC 1245 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 and *CHRE v NMC and Grant*.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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*.'

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 Ms Winstanley's conduct did fall significantly short of the standards expected of a registered nurse, and that Ms Winstanley's conduct amounted to a breach of the Code. Specifically:

*'**8 Work co-operatively***

To achieve this, you must:

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

8.6 share information to identify and reduce risk

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 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

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

To achieve this, you must:

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

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

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'.

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

The panel had regard to the NMC guidance on '*misconduct*'. It also considered the NMC guidance on '*how we determine seriousness*' and in particular, it noted the following:

'*Some behaviours are particularly serious as they suggest there may be a risk to people receiving care; examples include:*

- *...*
- *misconduct otherwise involving... abuse or neglect of children and/or vulnerable adults.*

...

Safeguarding and protecting people from harm, abuse and neglect is an integral part of providing safe and effective care. It is also a key principle embedded throughout our Code.

...

Protecting people from harm, abuse and neglect goes to the heart of what nurses, midwives and nursing associates do. Failure to do so, or intentionally causing a person harm, will always be treated very seriously due to the high risk of harm to those receiving care, if the behaviour is not put right...'

The panel considered that the incident involving Colleague A and Resident IH was serious and related to the potential abuse of a vulnerable resident in their care. The panel was of the view that as Home Manager, Ms Winstanley held a position of authority and thus she should have recorded and/or reported a serious safeguarding concern of that nature.

The panel therefore found that by not recording and/or reporting the safeguarding incident involving Resident IH, Ms Winstanley's omission fell 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, Ms Winstanley's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library on impairment, updated on 27 February 2024, which states:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) ...’*

The panel was satisfied that limbs a), b) and c) were engaged in this case. It found that a resident was put at risk of harm as a result of Ms Winstanley’s misconduct in failing to record and/or report the safeguarding incident. Ms Winstanley’s misconduct breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel noted Ms Winstanley’s reflection dated 26 September 2021, where she accepted her omission at charge 1, provided an explanation for the omission, demonstrated remorse and stated how she would handle the situation differently in the future. However, the panel was of the view that this reflection was limited and it was not satisfied that Ms Winstanley had demonstrated full insight. Despite Ms Winstanley’s admissions and remorse, the panel considered that she had not demonstrated an understanding of how her actions put Resident IH at a risk of harm, why what she did was wrong and how this impacted negatively on the reputation of the nursing profession. In

addition, the panel noted that Ms Winstanley had chosen not to engage with the NMC (which she had communicated to the NMC via her former RCN representative on 27 March 2024) and the panel had not seen any further reflection from her.

The panel was satisfied that the misconduct in this case is potentially capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Ms Winstanley has taken steps to strengthen her practice. The panel took into account that after leaving Greengables Nursing Home, Ms Winstanley subsequently worked at Bay Nursing Home. It noted that Ms Winstanley's misconduct related to her work as a Home Manager, rather than her nursing practice. However, given Ms Winstanley's lack of engagement with the NMC, the panel had no information about whether Ms Winstanley had addressed the concern around recording/reporting safeguarding incidents.

The panel was therefore not satisfied that Ms Winstanley can currently practise safely, kindly and professionally.

In light of the limited information before it, the panel found that there is a risk of repetition and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

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 which concerned Ms Winstanley not recording and/or reporting a safeguarding incident involving an elderly and at risk resident. It therefore also found Ms Winstanley's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Winstanley's fitness to practise is currently impaired.

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the NMC's Statement of Case attached to the Notice of Meeting, dated 23 May 2024, the NMC had advised Ms Winstanley that it would seek the imposition of a striking-off order if the panel found Ms Winstanley's fitness to practise currently impaired.

In its written submissions, the NMC stated:

> '*46. The NMC considers the following sanction to be proportionate:*
>
> *Striking-off order.*
>
> *47. The aggravating factors in this case are:*
> - *Vulnerable service users.*
> - *Limited insight.*
> - *A pattern of misconduct over a period of time.*
> - *Real risk of significant harm.*
>
> *48. No mitigating factors have been identified.*

49. As per the NMC's guidance on sanction, all available sanctions have been considered starting with the least severe:

49.1 No action

This sanction would not be appropriate as there are no exceptional circumstances that would warrant taking no action if found currently impaired.

47.2 Caution Order

Considering the seriousness of the concerns in this case, a caution order is not appropriate. Caution orders are suitable where the concerns are at the lower end of the spectrum of impaired fitness to practise.

47.3 Conditions of Practice Order

As per the guidance, some factors to determine whether conditions may be appropriate are as follows:

- *No evidence of harmful deep-seated personality or attitudinal problems.*
- *Potential and willingness to respond positively to retraining.*
- *Conditions can be created that can be monitored and assessed.*

The Registrant appears to have an attitudinal problem. In response to the complaint regarding resident IH, the registrant said, "oh no, not a-bloody-gain" and appeared angry/ frustrated. The Registrant has not worked as a nurse since these incidents. There is no indication that the Registrant would respond positively to retraining. As such, workable and measurable conditions cannot be put in place.

47.4 Suspension Order

A suspension order is not appropriate in this case as this is not a single instance of misconduct and there is evidence of harmful deep-seated personality/ attitudinal problems. The Registrant has demonstrated limited insight into the concerns.

47.5 Striking-off order

*The Registrant's misconduct is fundamentally incompatible with continued registration. A striking-off order is the appropriate sanction in this case***.'**

The panel noted that the NMC's submissions were made on the basis of charge 1 and charge 2 being found proved. The panel had found charge 2 not proved in its entirety.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Ms Winstanley's misconduct related to an elderly at risk service user.
- Ms Winstanley has demonstrated limited insight into her misconduct.

The panel also took into account the following mitigating features:

- Ms Winstanley made an early admission to her omission at charge 1.

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 then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Winstanley's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is*

at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Ms Winstanley's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Winstanley's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

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

The panel was satisfied that conditions of practice could be put in place to robustly manage the concern relating to safeguarding recording and/or reporting. However, it had no evidence that Ms Winstanley is willing to engage with conditions of practice in any meaningful way. The panel therefore found that there were no practical or workable conditions that could be formulated.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*

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

The panel considered that this was a single instance of misconduct where a lesser sanction would not be sufficient. There was no evidence before the panel of a harmful deep-seated personality or attitudinal problem with Ms Winstanley, nor was there any evidence of repetition since the incident. The panel was satisfied that Ms Winstanley had only demonstrated limited insight.

In light of Ms Winstanley's limited insight, the panel considered that there was a continued risk to patient safety. It determined that this was a serious case that warranted her temporary suspension from nursing practice.

The panel noted that a suspension order would temporarily prevent Ms Winstanley from working as a registered nurse. It was satisfied that such an order would give Ms Winstanley time to re-engage with the NMC; reflect on her misconduct; strengthen her practice; and provide developed insight into the impact of her misconduct on patients, colleagues and the wider profession; and to decide on her future intentions as to her nursing career.

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with Ms Winstanley remaining on the register.

The panel did go on to consider whether a striking-off order would be proportionate. It noted that the NMC was seeking a striking-off order in this case on the basis of all of the charges being found proved. However, taking into account its findings on the charges and on misconduct and impairment in respect of charge 1 only, the panel concluded that such an order would be disproportionate. Whilst the panel acknowledged that a suspension order may have a punitive effect, it would be unduly punitive in Ms Winstanley's 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 determined such an order would suitably protect the public and meet the wider public interest.

The panel noted the hardship such an order may cause Ms Winstanley. 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 standards of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct and provide Ms Winstanley the opportunity to reflect on the future of her nursing registration and communicate her intention to the NMC and a future reviewing panel.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, it may allow the order to lapse upon expiry, it may extend the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Ms Winstanley's engagement and attendance at the substantive order review hearing.
- A detailed written reflective account which addresses the concerns found proved and demonstrates how Ms Winstanley has developed her insight into her misconduct, how she has reflected on that and how she would act in the future in a similar situation.
- Any evidence of training and/or strengthened practice.
- Clear evidence/information from Ms Winstanley as to her future intentions regarding her nursing registration.

This will be confirmed to Ms Winstanley in writing.

Interim order

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

Representations on interim order

The panel took into account the NMC's written representations on interim order, which stated:

> '*If a finding is made that the Registrant's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, the NMC consider an interim suspension order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *If a finding is made that the Registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registration, the NMC consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.*
>
> *The purpose of an interim order is to cover the gap between the making of any substantive order and the statutory appeal window or any actual appeal. Should no appeal be lodged, or an appeal be resolved, the interim order would fall away.*'

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 ensure that Ms Winstanley cannot practise unrestricted before the substantive suspension order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

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

That concludes this determination.