Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 21 October 2024

Virtual Hearing

Name of Registrant:	**Sheik Mohamed Reshad Ali Osman Torabally**
NMC PIN	91A1951E
Part(s) of the register:	Sub Part 1 RN3: Mental health nurse, level 1 (1 April 1994)
Relevant Location:	Leicester
Type of case:	Misconduct
Panel members:	Debbie Hill (Chair, Lay member) Pamela Campbell (Registrant member) Jane Dalton (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Petra Bernard
Nursing and Midwifery Council:	Represented by Assad Badruddin, Case Presenter
Mr Torabally:	Present and represented by Sheik Iqbal Torabally, Mascot Solicitors
Consensual Panel Determination:	Amended
Facts proved by admission:	All charges
Facts not proved:	None
Fitness to practise:	Impaired

Sanction:	**Conditions of practice order (12 months) with review**
Interim order:	**Interim conditions of practice order (18 month)**

Details of charge

That you, a registered nurse, whilst working at Ashleigh Nursing Home ('the Home') as Registered Manager:

1) Did not follow safeguarding requirements, in that in April 2021:

   a) In relation to Resident A, a Deprivation of Liberty Safeguards ('DoLS') renewal was not submitted to the local authority following their DoLS expiring on 22 January 2021;

   b) In relation to Resident B, a risk assessment was not carried out for an arrangement whereby a staff member took Resident B's bank card and PIN to buy them cigarettes and/or this arrangement was not documented;

   c) In relation to 2 residents receiving medicines covertly, there was no record to show:

      i) that the required mental capacity assessments had taken placed before administering their medication covertly;

      ii) the aims and/or purpose of the medication.

2) Did not ensure staff training was adequate, in that on 1 and 6 April 2021:

   a) There was no evidence that staff members' understanding of training completed had been checked and/or was being implemented by staff;

   b) Staff were not implementing correct moving and handling techniques;

   c) Staff training was not up to date;

   d) The Home's training matrix did not include all staff members.

3) Did not ensure staff were organised, in that on 1 and 6 April 2021:

a) staff did not have clear direction around the allocated duties and responsibilities for residents;

b) there was no system in place to routinely check on residents;

c) no one checked whether staff were managing and/or needed assistance.

4) Did not ensure that adequate care plans and/or risk assessments were in place for one or more residents, in that in April 2021:

a) There was no evidence that Resident A's weight and/or skin integrity was being monitored and/or recorded.

b) In relation to Resident C:

i) They were not weighed on admission to the Home;

ii) There were no daily care notes for 29 and 30 March 2021;

iii) There was no care plan and/or risk assessment in place.

c) There was no care plan and/or risk assessment in place for Resident D.

d) In relation to Resident E:

i) Their care plan was not up to date in that there was no detail about a catheter being in place;

ii) There was no evidence that the resident's catheter was being monitored;

iii) There was no reasoning recorded for a bladder washout on 25 March 2021.

e) In relation to Resident F, who was prescribed insulin:

i) there was no 'hyper/hypo rescue plan' in place

ii) blood glucose levels were not always recorded daily.

5) Did not maintain adequate standards of record keeping, in that during care quality visits from 2016 to 2019:

   a) Patient care plans frequently lacked sufficient detail;

   b) Risk assessments were not always completed;

   c) Policies were not always up to date and/or lacked sufficient detail;

   d) Resident's monthly weights were not always recorded;

   e) Position charts for service users with pressure sores did not contain adequate information.

6) Did not maintain equipment at the Home to the required standard, in that in April 2021:

   a) There were lightbulbs missing in some areas of the premises, resulting in poor lighting in some areas;

   b) There were numerous wheelchairs at the Home without footplates;

   c) Mattresses did not meet the required standards;

   d) Bed rails and bumpers were damaged.

7) Did not ensure safe storage of medication, in that in April 2021:

   a) The controlled drugs register was made up of loose paper, instead of kept as bound book;

   b) On one or more occasions the controlled drugs register was only signed by one staff member, instead of the required two staff members;

   c) Eye drops and/or liquid medicines were not always dated when opened;

   d) The medication fridge was not kept locked;

e) The door to the treatment room was not kept locked.

8) Did not ensure medication was administered and/or managed adequately, in that in April 2021:

a) 2 residents receiving pain medication via trans-dermal patches did not have up to date charts and/or daily checks;

b) In relation to a resident prescribed Co-Careldopa, there was no evidence that the medication had been administered at the prescribed times.

9) Did not ensure adequate infection control measures were in place, in that in April 2021:

a) There was no system in place to check residents' mattresses;

b) The high-risk cleaning rota had not been followed in that there were several gaps in the rota;

c) There were dried faeces on a pillow case in Resident C's room;

d) The Home did not have 'no touch' waste bins;

e) Staff did not always apply training in donning and doffing PPE.

10) Did not ensure records of staff recruitment were kept, in that in April 2021 information was missing in 2 applications about staff member's:

a) Qualifications;

b) Employment history;

c) Interview questions and responses.

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

Consensual Panel Determination

At the outset of this hearing, Mr Badruddin informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the NMC and you.

The agreement, which was put before the panel, sets out your full admissions to the facts alleged in the charges, that your actions amounted to misconduct, and that your fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a conditions of practice order for a period of 12 months, with review.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

'The Nursing & Midwifery Council ('the NMC') and Sheik Mohamed Reshad Ali Osman Torabally, PIN 91A1951E ('the Parties') agree as follows:

1. Mr Torabally is aware of the CPD hearing. Mr Torabally does not intend on attending the hearing and is content for it to proceed in his and his representative's absence. Mr Torabally and/or his representative, Mr Sheik Iqbal Torabally of Mascot Solicitors, will endeavour to be available by telephone should clarification on any point be required, or should the panel wish to make other amendments to the provisional agreement that are not agreed by Mr Torabally.
2. Mr Torabally understands that if the panel wishes to make amendments to the provisional agreement that he doesn't agree with, the panel will reject the CPD and a further substantive hearing will be scheduled.

The charge

3. Mr Torabally admits the following charges:

That you, a registered nurse, whilst working at Ashleigh Nursing Home ('the Home') as Registered Manager:

1) Did not follow safeguarding requirements, in that in April 2021:

a) In relation to Resident A, a Deprivation of Liberty Safeguards ('DoLS') renewal was not submitted to the local authority following their DoLS expiring on 22 January 2021;

b) In relation to Resident B, a risk assessment was not carried out for an arrangement whereby a staff member took Resident B's bank card and PIN to buy them cigarettes and/or this arrangement was not documented;

c) In relation to 2 residents receiving medicines covertly, there was no record to show:

i) that the required mental capacity assessments had taken placed before administering their medication covertly;

ii) the aims and/or purpose of the medication.

2) Did not ensure staff training was adequate, in that on 1 and 6 April 2021:

a) There was no evidence that staff members' understanding of training completed had been checked and/or was being implemented by staff;

b) Staff were not implementing correct moving and handling techniques;

c) Staff training was not up to date;

d) The Home's training matrix did not include all staff members.

3) Did not ensure staff were organised, in that on 1 and 6 April 2021:

a) staff did not have clear direction around the allocated duties and responsibilities for residents;

b) there was no system in place to routinely check on residents;

c) no one checked whether staff were managing and/or needed assistance.

4) Did not ensure that adequate care plans and/or risk assessments were in place for one or more residents, in that in April 2021:

a) There was no evidence that Resident A's weight and/or skin integrity was being monitored and/or recorded.

b) In relation to Resident C:

i) They were not weighed on admission to the Home;

ii) There were no daily care notes for 29 and 30 March 2021;

iii) There was no care plan and/or risk assessment in place.

c) There was no care plan and/or risk assessment in place for Resident D.

d) In relation to Resident E:

i) Their care plan was not up to date in that there was no detail about a catheter being in place;

ii) There was no evidence that the resident's catheter was being monitored;

iii) There was no reasoning recorded for a bladder washout on 25 March 2021.

e) In relation to Resident F, who was prescribed insulin:

i) there was no 'hyper/hypo rescue plan' in place

ii) blood glucose levels were not always recorded daily.

5) Did not maintain adequate standards of record keeping, in that during care quality visits from 2016 to 2019:

a) *Patient care plans frequently lacked sufficient detail;*

b) *Risk assessments were not always completed;*

c) *Policies were not always up to date and/or lacked sufficient detail;*

d) *Resident's monthly weights were not always recorded;*

e) *Position charts for service users with pressure sores did not contain adequate information.*

6) *Did not maintain equipment at the Home to the required standard, in that in April 2021:*

a) *There were lightbulbs missing in some areas of the premises, resulting in poor lighting in some areas;*

b) *There were numerous wheelchairs at the Home without footplates;*

c) *Mattresses did not meet the required standards;*

d) *Bed rails and bumpers were damaged.*

7) *Did not ensure safe storage of medication, in that in April 2021:*

a) *The controlled drugs register was made up of loose paper, instead of kept as bound book;*

b) *On one or more occasions the controlled drugs register was only signed by one staff member, instead of the required two staff members;*

c) *Eye drops and/or liquid medicines were not always dated when opened;*

d) *The medication fridge was not kept locked;*

e) *The door to the treatment room was not kept locked.*

8) *Did not ensure medication was administered and/or managed adequately, in that in April 2021:*

   a) *2 residents receiving pain medication via trans-dermal patches did not have up to date charts and/or daily checks;*

   b) *In relation to a resident prescribed Co-Careldopa, there was no evidence that the medication had been administered at the prescribed times.*

9) *Did not ensure adequate infection control measures were in place, in that in April 2021:*

   a) *There was no system in place to check residents' mattresses;*

   b) *The high-risk cleaning rota had not been followed in that there were several gaps in the rota;*

   c) *There were dried faeces on a pillow case in Resident C's room;*

   d) *The Home did not have 'no touch' waste bins;*

   e) *Staff did not always apply training in donning and doffing PPE.*

10) *Did not ensure records of staff recruitment were kept, in that in April 2021 information was missing in 2 applications about staff member's:*

   a) *Qualifications;*

   b) *Employment history;*

   c) *Interview questions and responses.*

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

The facts

4. *Mr Torabally appears on the register of nurses, midwives and nursing associates maintained by the NMC as a Registered Nurse – Mental Health. He has been on the NMC register since 01 April 1994.*

5. *On 15 November 2021, the NMC received a referral from the Care Quality Commission ('CQC') concerning Mr Torabally's fitness to practise.*

6. *Mr Torabally was employed by the Home as a staff nurse from 1997, until he became manager in 2000. He registered with the CQC, as Registered Manager on 26 October 2010 and remained the Home Manager and Registered Manager until 21 July 2021. As the Home Manager and Registered Manager, Mr Torabally was responsible for the day to day running of the Home, oversight of the quality of care provided, identification and subsequent risk intervention and oversight of governance.*

7. *The Home had a capacity of 21 beds and accommodated older adults (65 years old and over) who had been diagnosed with dementia, learning disability, mental health, physical disability and/or sensory impairment. It had been rated as 'requires improvement' by the CQC from 29 December 2016, and on 07 August 2019 the CQC imposed restrictions on the Home. Throughout this period, concerns were also being monitored by the Clinical Commissioning Group ('CCG').*

8. *On 01 and 06 April 2021, the CQC completed an inspection to check whether improvements had been made since the restrictions had been in place. The inspection was carried out alongside a Specialist Nurse Advisor and an Expert by Experience ('the ExE'), who is a person who has personal experience of using or caring for someone who uses the type of care which the service offers. Consequent to the inspection concerns were raised about Mr Torabally's management of the Home. The inspection revealed that the management of the Home was chaotic and mismanaged, and there were numerous concerns about the care being provided to residents under Mr Torabally's leadership.*

9. *Following the inspection, the CQC rated the Home "inadequate" and in breach of 7 regulation areas. The CQC served a letter of intent, dated 13 April 2021, to the Registered Provider setting out the immediate risks and the CQC's proposed enforcement action with respect to infection control, PPE guidance and risk assessment training. The Home was restricted from admitting any new residents after 15 April 2021.*

10. *The CCG reviewed all their funded residents, and on 21 June 2021, the CCG asked for their residents to be moved out "as soon as possible". The last resident left the Home on 21 July 2021 and the Home closed on 06 December 2021.*

Charge 1(a)

11. *DoLS allow a care provider to provide treatment or care to a resident where they are assessed to lack capacity to make informed decisions on receiving care. Therefore, if the resident requires care or treatment which is within their best interests to receive, the staff within the Home do not need the resident to consent to provide it. The DoLS will have different authorisations and conditions which the care staff must apply and follow when treating or caring for the resident. These conditions will be made following a mental capacity assessment of the resident.*

12. *Resident A was the Home's most frail resident, and she suffered from dementia. She was subject to a DoLS order effective from 24 January 2020, which expired on 22 January 2021. As the Registered Manager, it was Mr Torabally's legal responsibility to ensure that DoLS orders were in date and any further DoLS applications were submitted to the local authority for renewal in a timely manner. He however did not submit a DoLS renewal application for Resident A, which was identified during the inspection when the CQC Inspectors found the DoLS authorisation letter dated 31 January 2020 but no evidence of renewal. By not renewing the DoLS, the Home did not have the legal authority to deprive Resident A of their liberty and there was a risk that Resident A's best interests assessment had not been completed correctly.*

Charge 1(b)

13. *All the Home's residents, including Resident B, were vulnerable, which placed them at higher risk of financial abuse. Resident B's bank card and PIN was known to staff, who would take Resident B's card to buy her cigarettes. However, there was no record of Resident B's consent to this, a risk assessment having been undertaken to safeguard them from against financial abuse, nor of purchases made. This placed Resident B at risk of financial abuse. As the Registered Manager, Mr Torabally was responsible for implementing measures to ensure residents were protected from financial abuse and staff were protected against associated false allegations, but he had not done so.*

Charges 1(c)(i) and (ii)

14. *The National Institute for Health and Care Excellence's ('NICE') guidance entitled 'Giving medicines covertly' (2019) and guidance entitled 'Managing medicines in care homes (SC1) (2021) provide that if adults lack the mental capacity to make decisions about their health or medicines and it is assessed as being in their best interests, they may need to be given medicines without their knowledge or consent (covertly) i.e., hidden in food or drink. Altering the medication's form for covert administration e.g., crushing or opening capsules may alter the properties of the medication. Furthermore, the resident may absorb the medication quicker than intended and suffer side effects. Separately, adding medication to food and drinks may affect the active ingredient or how they are absorbed if more than one tablet is taken together.*

15. *The process for covert medication administration includes assessing the resident's mental capacity, holding a best interest meeting between care home staff, the prescriber, the pharmacist, and resident's family member or advocate to agree if covert administration is in the resident's best interest. The reasons for presuming mental incapacity and proposed management and action plan should be recorded, and there should be regular reviews to determine if covert administration is still needed.*

16. *Two of the Home's residents were receiving medication covertly. The CQC Inspectors found no protocols attached to the residents' medication administration records to*

evidence that mental capacity assessments, best interest meetings, or medical reviews and best interest meetings had taken place, or that the pharmacist had been consulted as to the safe method of administration.

17. *The residents' records also did not include the aims and/or purpose of each medication being administered covertly e.g., 'deemed necessary to prevent deterioration in the resident's mental health'. These omissions placed the residents at risk of harm.*

18. *As the Registered Manager, Mr Torabally was responsible for implementing the medication policies, and ensuring staff follow them. He should have carried out monthly audits and noted any shortcomings in relation to medication management (such as issues with the procedures and protocols in place). He would have received training on the Mental Capacity Act 2005 ('MCA') framework and therefore was expected to have good knowledge and understanding of when it was necessary to deprive a resident of their ability to consent to treatment, and the need to conduct mental capacity assessments before a resident received medication covertly. Section 4.8 of the Home's 'Overarching Medication Policy (CN02)' stated: 'The Registered Manager is responsible for: … Ensuring that a mental capacity assessment forms part of a person-centered care plan and consent to support medication is obtained…; Ensuring that where best interest decisions are required, this is done in collaboration with others involved in the RESIDENTS's care and is recorded and shared with relevant staff; Ensuring that capacity in relation to the management of medication is reviewed regularly…'*

Charge 2

19. *As the Registered Manager, Mr Torabally was responsible for ensuring that staff training was adequate and any refresher courses were arranged, equip them with the appropriate skills for their role, but he did not.*

(a)

20. *There was no evidence that staff knowledge about training completed had been checked in areas such as safeguarding adults and moving and handling of residents.*

There was no evidence to establish whether staff understood their role with reference to the training completed, how to meet residents' needs, keep them safe, and report concerns about resident's health to Mr Torabally or the nurse on duty. This presented the risk that staff did not know what abuse looks like and would consequently fail to report concerns. For example, during the inspection staff did not provide any reassurance to a resident who suffered from dementia and had called out for their parent, which had increased the resident's anxiety. This demonstrated lack of insight and understanding of how dementia affects people, and their role as staff to provide effective care.

21. *Staff had received training in the prevention and control of infection but did not regularly clean high risk surfaces, including toilets, after people used them. This placed staff and residents at risk of acquiring contagious diseases.*

(b)

22. *Staff did not implement correct moving and handling techniques. This placed residents at risk of harm, should staff have attempted to move them using incorrect methods.*

(c) and (d)

23. *Staff training was not up to date. For example, the safeguarding and moving and handling training for some had expired. Furthermore, the training matrix used to record staff training did not include all staff members e.g., maintenance staff and a newly recruited nurse had been omitted. They were therefore not fully trained in their roles to ensure they had the required skills and level of competence.*

Charges 3(a)-(c)

24. *Mr Torabally did not, as the Registered Manager, ensure that staff were clear on their allocated duties and responsibilities, implement a system to routinely check on residents, or ensure staff were managing their workload.*

25. *The staff did not have a clear direction around their allocated duties and responsibilities for residents. They would rush from one resident to another in the lounge, and between*

residents' bedrooms, appearing to led by tasks as opposed to responding to the residents' needs.

26. *There was no system in place to routinely check on residents. On multiple occasions the CQC Inspectors came across residents calling out for help and support because their call bells were out of their reach, and they needed to locate staff to attend to residents.*

27. *Mr Torabally did not check on staff to ensure if they were managing or needed assistance. During the inspection he went to the bank with the Home Owner, leaving the staff with no support and the Home with no managerial oversight.*

Charge 4(a)

28. *As mentioned above, Resident A was the Home's most frail resident. She weighed 34kg and suffered from pressure sores, for which she needed an airflow mattress. Her care plan stated that she needed to be repositioned every two hours based on her Waterlow score, which classified her as being at very high risk for developing pressure ulcers. This was not done. Resident A repositioning chart from 01 March to 06 April 2021 did not state the frequency of repositioning required. showed she had not been repositioned consistently on 02, 03, 04, 06, 10-14, 18-21, and 25-27, 29-31 March, and 01-05 April 2021.*

29. *There were no records to confirm that Resident A's weight was being monitored. Weight loss/low weight can occur for numerous reasons (e.g., psychological or mental health conditions such as depression, or poor dental care). It is important in these situations to monitor for weight, and where necessary refer to the GP and/or dietician for further investigation and support. Failure to do this could result in the patient deteriorating physically and mentally which could place them at increased risk of infection and ill health and ultimately death. Poor nutrition has wide-ranging consequences e.g., increased risk of development of pressure ulcers.*

30. *There were no records confirm that daily checks of the working condition of the mattress and mattress setting was completed. The chart did not include the correct*

mattress setting and it was omitted in the care plan. The Inspectors found that Resident A's mattress was set to 'firm', which was incorrect. During the inspection, Mr Torabally informed the Inspectors that they did not know how to complete a core mattress test to check the condition of the mattress.

31. *Omitting detailed information within a care plan could have serious consequences. With Resident A, the lack of detail could have caused her required care to be overlooked by staff, increasing the risk of a pressure ulcer developing. Pressure ulcers can be fatal if infection occurs.*

32. *Care plans inform the care staff of what is required to meet an individual's care needs. They should therefore be detailed, and person centred to reflect an individual's preferences and choices. This is a basic core skill for a registered nurse to write a comprehensive care plan and risk assessment, and review this at least monthly (or if there is a change, such as a fall or wound). The quality of care planning should have been monitored by Mr Torabally as the Registered Manager. He should have via the audit process identified the gaps in the care Resident A was receiving, what measures were needed to reduce the risk, and ensured that staff were aware of what Resident A required and that her care plans were adequately detailed.*

Charge 4(b)(i)-(iii)

33. *Resident C was admitted to the Home on 29 March 2021. Her transfer paperwork recorded that she had a poor appetite and had lost a lot of weight. She arrived with blisters on her feet, which were body mapped and photographed, and was identified as high risk for developing pressure ulcers due to very fragile skin. On review of the paperwork the CQC Inspectors found no evidence that Resident C had been weighed on admission, despite receiving notice of her low weight.*

34. *There were also no daily care notes for 29 and 30 March 2021. Despite the fact that her electronic care summary record stated 'please record all of my dietary and fluid intake', this information had not been recorded. Resident C was cared for on an airflow mattress to manage the risk to her skin but there was no completed repositioning chart*

to show that she had been repositioned, nor were there any daily mattress check records. Nothing had been recorded to evidence action that had been taken in response to Resident C's poor appetite and a fluid watch chart had not been started. She was consequently at risk of dehydration, malnutrition, and skin breakdown/pressure ulcers.

35. *There was no Waterlow i.e., risk assessment, undertaken with reference to Resident C's tissue viability concerns or care plan setting out how the risk of skin breakdown was to be managed. Resident C's condition deteriorated, and she was admitted to hospital on 02 April 2021 in severe pain.*

36. *Care plans are a fundamental part of nursing at a nursing home. Without the care plans in place, new or agency staff coming into the Home would not be aware of the risks or needs of a particular resident and would not be able to provide adequate care to the resident, or adequately prevent risks to the resident.*

37. *The Home's policy on new admissions stated at section 5.11 under the heading "On the Day of Admission" that "all assessment documentation will be readily accessible and held in the RESIDENT's Care Plan…" and that "…Care Plans and risk assessments should be developed with the RESIDENTS (within 24 hours of admission, or documented as to why this could not be achieved)". It goes on to state at 5.13 under the heading that "Within the first month" that 'All RESIDENTSs will have a full assessment carried out within three days of admission and all Care Plans will be complete within 7 days.'*

38. *As the Registered Manager, Mr Torabally was responsible for the clinical oversight of the Home and for ensuring that the residents' needs were met. He would have known from experience that he was required to ensure that care plans and risk assessments were completed/undertaken promptly and to an adequate standard to provide a good standard of care. These were required to reduce the risk of harm. Residents were admitted to the Home with their needs and risks already known, but Mr Torabally failed to ensure that care planning was in place to manage these risks.*

Charge 4(c)

39. *Resident D was admitted to the Home on 17 March 2021 and was at a high risk of falls. This was recorded in his care records. The CQC Inspectors found that there was no record that the Home had undertaken a falls risk assessment or created a care plan to mitigate his risk of falls. As with Resident C, it was Mr Torabally's responsibility to ensure that these had been completed.*

Charge 4(d)(i) and (ii)

40. *Resident E suffered from Parkinson's Disease and had an indwelling catheter due to an enlarged prostrate.*

41. *NICE guidance CG39 entitled 'Health care-associated infections: prevention and control in community care' (2012) identifies indwelling catheters to be a high-risk area. Checks should be completed to ensure the connection between the catheter and the drainage system is not broken. The drainage bag is positioned below the bladder and should not be in contact with the floor. The bag should be emptied frequently to maintain urine flow and prevent reflux. The site should be cleaned daily with soap and water to minimise the risk of blockage, encrustations and other catheter associated infections associated with long term indwelling catheters and increase fluid intake.*

42. *On inspection of his records there was no daily catheter log to document any issues with the catheter, or record of when the last catheter change took place or when the next was due. Catheters are usually changed every 12 weeks unless there is a clinical need to do so. The then current care plan did not provide detail about Resident E having a catheter in situ, or guidance to staff on the general care and management for the catheter. There was no documentary evidence of the catheter site being inspected and cleaned daily. Whilst there is no universally implemented document used by care homes to record cleaning the catheter site, this information was not included in Resident E's electronic records, daily notes, and physical records.*

43. *There was a chart in place to monitor Resident E's fluid intake and output, but this was not fully completed e.g., some entries only stated that the bag had been emptied, not*

the amount. Debris clouds the urine and is more common the longer a catheter is in place. Blood is more often a sign of infection, and a blocked catheter can cause a lot of pain and requires urgent attention. Reduced urine output can be an indicator that there is a catheter leak or blockage. Thus, the monitoring of the volume and what is voided is clinically appropriate to inform and ensure appropriate action is taken in a timely manner.

Charge 4(d)(iii)

44. *The CQC Inspectors noted that there was a record of Resident E having a bladder washout on 25 March 2021. However, there was no record of why this had been undertaken.*

45. *As with Residents B, C and D, Mr Torabally was responsible for ensuring that the risk assessments had been completed and care plans were up to date with all relevant information included. During the inspection, Mr Torabally acknowledged that Resident E's care plan lacked the necessary detail to ensure safe and effective management of long-term in-dwelling catheters.*

Charge 4(e)(i) and (ii)

46. *Resident F was prescribed Insulin to treat their diabetes. Their blood glucose monitoring chart stated their glucose levels needed to be checked twice daily. Resident F's chart showed that between 10 March 2021 and 01 April 2021, twice daily monitoring had only taken place on 11 and 31 March 2021. Furthermore, Resident F did not have a hyper/hypo rescue plan attached to their MAR chart. This meant that staff had no guidance on what action they should have taken if Resident F's glucose levels fell outside the normal range. The lack of monitoring and rescue plan placed Resident F at risk of becoming very unwell.*

47. *It was Mr Torabally's responsibility to ensure care plans were up to date with all relevant information included, and staff were providing residents with appropriate care.*

Charge 5

48. *The Clinical Commissioning Group ('CCG') conducts annual quality visits ('I-Care audits') to care homes that provide their services to residents whose care was funded by the CCG. If there are concerns about a home, more frequent visits will be undertaken to ensure the concerns have been rectified. The visits are scored as a percentage via a quality audit tool. The minimum expected score is 85%; any lower is considered as 'poor'.*

49. *After the I-Care audits were taken in-house by the CCG in 2016, an I-Care audit was completed on 27 July 2016. The Home achieved a score of 81% as a result of several concerns and was placed on an action plan. Follow-up visits were conducted on 19 October 2016, 06 February and 10 July 2017, 07 August and 06 December 2018, 16 July, 16 October, and 20 November 2019, and yet concerns remained.*

50. *As the Registered Manager and most senior clinician at the Home, Mr Torabally should have had clinical oversight of the areas of concerns raised. He should have acted on the feedback issued by the CCG and implemented changes to rectify them, but he did not.*

(a)

51. *The care plans inspected on 27 July 2016 did not always meet the holistic needs of the residents e.g., one care plan referred to actions to take if a resident's blood sugar was not in the 'normal' range but did not detail what was considered normal for the resident, and were generally of a poor quality overall. Some care plans did not identify residents' targets and goals or how they were to be achieved. one did not state what the problem was and had been left blank. A breathing care plan for a resident prone to chest infections did not include details of what action staff should take if the resident were to become breathless, other than to contact the GP.*

52. *There was information contained in some daily records and ABC charts that had not been transferred into the care plan. Cognition care plans did not refer to mental capacity or evidence how care decisions were being made in the residents' best*

interests. Multidisciplinary input was not reflected in the care plans. One resident's record identified that antibiotics had been prescribed for a urinary tract infection in the past which was not first or second line treatment as per Leicestershire's Antimicrobial Policy for Primary care, but there was no evidence in the care plan that the GP's decision to prescribe out of guidance had been based on urine specimen results, or the rationale for the decision.

53. *The visit of 10 July 2017 identified that that although the Home achieved a score of 93%, issues remained with the quality of care plans. Separate care plans had not been created where a resident had a specific medical condition. Nutritional care plans tended to omit daily fluid goals where a resident's fluid intake was being monitored, expected blood glucose ranges were not specified, and details of the type of pressure relieving equipment and use of repositioning were missing from pressure ulcer care plans.*

54. *The visit of 06 November 2018 identified that issues remained with the quality of care plans. Care plans for residents at high risk of falls did not include detail of how the risk would be managed. Those for residents with a history of seizures did not have detailed care plans identifying potential triggers and specifying how to care for the resident during and after a seizure. Care plans for daily lifestyle required more information about the residents' preferences to enable person-centered care. A care plan for a service user who could present with challenging behaviour did not contain enough detail about de-escalation techniques to be followed by staff.*

55. *The visit of 16 July 2019 identified that although the Home achieved a score of 88%, issues remained with the quality of care plans. Separate specific care plans for residents with diabetes and challenging behaviours had not been created. In one care plan the resident's Waterlow and MUST scores were incorrectly calculated, which could have resulted in risks not being identified. Tissue viability care plans lacked essential clinical detail e.g., pressure relieving equipment being used and frequency of repositioning. Nutrition care plans contained vague statements e.g., 'adequate diet and fluids', which was insufficient detail.*

(b)

56. *The visit of 27 July 2016 identified that no care records reviewed had pre-assessment documents to evidence that Mr Torabally had considered whether the Home was able to meet the residents' care needs. Post-admission assessment forms either lacked detail or were incomplete. Information in the daily records had not been transferred to risk assessments. Bed rail risk assessments were not always completed monthly. The visit of 22 October 2016 identified that risk assessments were still not being reviewed monthly or where there had been a change in the resident's condition. The visit of 07 August 2018 identified that no behaviour risk assessments had been completed for residents who could present with challenging behaviour. The visit of 16 July 2019 identified that behaviour risk assessments for residents who could present with challenging behaviour were still missing. The visit of 20 November 2019 identified that a newly admitted resident was missing basic risk assessments.*

(c)

57. *The visit of 16 July 2016 identified that there was no bed rail policy in the home that detailed how to risk assess for bed rails. Policies were overdue their yearly reviews e.g., for receipt, storage, handling and administration of medicines, and some contained information that was out of date and therefore needed to be archived e.g., infection control policy. Policies were found to be overdue yearly reviews and/or out of date on visits of 23 October 2016, 10 July 2017 and 07 August 2018.*

(d)

58. *The visit of 27 July 2016 identified that gaps in residents' weight charts. The visit of 16 July 2019 identified that monthly weights were not always being recorded. This presented the risk that residents losing weight would not be identified and provided required additional support.*

(e)

59. *The visit of 16 July 2019 further identified that position charts were in use for residents at risk of pressure ulcers, but this did not always indicate that the service user was being assisted at the frequency specified in the care plan. The visit of 16 October 2019 identified that there were gaps in a resident's position change charts. The visit of 20 November 2019 identified that position charts indicated repositioning was not always at the intervals specified in the care plan.*

Charges 6(a)-(d)

60. *During the CQC inspection in April 2021, there were lightbulbs missing in some areas of the Home, which meant the lighting was poor in those places. This increased the risk of falls for residents, particularly if they were visually challenged or were navigating those areas late at night.*

61. *There were several wheelchairs without footplates, which placed residents at risk of harm e.g., their foot could have become trapped under the wheelchair whilst being pushed.*

62. *There were mattresses that did not meet the required standard e.g., that in room 15 had a dirty zip and badly dipped in the centre. Mattresses with significant dips do not provide good posture support. Furthermore, if a resident is incontinent, urine can pool in the dip, which in turn presents the risk of skin damage if the resident's skin is in contact with the pooled urine for prolonged periods. Bedrails and bumpers were damaged. These are required to protect residents from rolling out of bed, hence their damage presented the risk of injury to residents. Mr Torabally informed one of the Inspectors that he 'was not aware of how to test mattresses' and there was no system in place to test them.*

63. *Mr Torabally was responsible for ensuring the Home's equipment was fit for purpose, which it was not. He should have conducted environmental checks to meet this requirement, identified the issues, and implemented steps to rectify them.*

Charge 7

64. *Mr Torabally was responsible for the safe storage of medication in the Home but he did not ensure that systems were put in place and/or adhered to in order to meet this responsibility, as per the NICE's guidance on 'Managing medicines in care homes', particularly sections 1.1.2, 1.12.1, and 1.12.2.*

(a)

65. *The Home's 'Controlled Drugs Policy and Procedure (CN09)' specified at section 5.4 that the controlled drugs ('CD') register '…must be a bound book with numbered pages.' This is also set out in the Government's guidance on CD registers. The Home's CD register comprised of a loose-leaf file that was not properly bound. This presented the risk that the pages would become loose and lost.*

(b)

66. *On one of more occasions the CD register was signed by only one staff member. It is good practice to have entries witnessed by a second checker. This was also a requirement set out at section 5.1 and 5.2 of the Home's CD policy.*

(c)

67. *Eyedrops and/or liquid medicines were not labelled with the date they had been opened. These medicines usually have a 28-day shelf life, after which they should not be used. Thus, the absence of the opening date presented the risk that medicines would be administered to patients once their shelf-life had elapsed. If medicines exceed their shelf-life/expiry date, there is a risk that they will no longer be effective*

(d)

68. *The medication fridge in the nurses' station was not kept locked. This is a safety measure to ensure the fridge is not left open and therefore the medications within remain cold.*

(e)

69. *The door to the treatment room was not kept locked. This meant that residents could potentially access the area and medication trolley. This presented the risk of residents ingesting medication not prescribed for them, which could have had a detrimental effect on their health.*

Charge 8

70. *Mr Torabally was responsible for ensuring the safe administration and management of medication in the Home and implementing and ensuring adherence to policies to achieve this aim, but he did not. The issues identified should have been identified and rectified by Mr Torabally during his monthly medication audits.*

(a)

71. *Two residents were receiving pain medication via transdermal patches. There were however no up-to-date charts recording the number and location of sites where the patches had been applied, nor of daily checks to ensure the patches were still in place. Application sites are rotated to avoid sensitivities and thinning of the skin developing. If this happens, the rate of drug absorption into the blood stream can be higher, leading to overdose. Use of charts reduces the risk of this occurring. If patches fall off or are accidentally removed, the resident can be left in unnecessary pain. This risk is exacerbated if there are barriers to communication e.g., the resident is non-verbal. The requirement to complete patch checks and rotate sites was set out in the Home's 'Other Routes of Medication Administration Policy and Procedure' at sections 5.10 and 5.12. Mr Torabally should have ensured these were taking place and documented.*

(b)

72. *One patient had been prescribed Co-Careldopa to treat the symptoms of Parkinson's Disease, which needs to be given at specific times. There was no record of the times at which the medication had been administered. This meant there was a risk that the patient had not received the medication at the relevant times and therefore their*

symptoms had not been managed. In that instance, their motor skills would have been affected, inhibiting their ability to complete day-to-day activities.

Charge 9

73. *Mr Torabally had the overall responsibility for ensuring the Home was clean, but he did not ensure that adequate systems were in place so that infection control measures were followed.*

(a)

74. *There was no system in place to check residents' mattresses. Checking for damage to the core of the mattress is an important infection control measure as a damaged and compromised mattress cover leads to a contaminated core and is a major convector in the spread of healthcare acquire infections.*

(b)

75. *Although there was a high-risk cleaning rota, this was not followed. For example, the nursing station was meant to be cleaned thrice a day but there were several gaps in the rota, indicating this had not been done. By not cleaning the high-risk areas frequently, it meant that there was a higher chance that infection and germs would spread through the Home.*

(c) – (e)

76. *There was dried faeces on a pillowcase in Resident C's room. This presented the risk of cross-contamination. The Home did not have 'no touch' waste bins, which would have reduced the spread of infections. Staff did not always apply training in donning and doffing personal protective equipment ('PPE'), therefore increasing the risk of cross-contamination. They were e.g., observed helping a resident to the toilet and not changing their PPE afterwards.*

Charge 10(a)-(c)

77. *Mr Torabally was responsible for maintaining records for staff, which would include any records of their qualifications, employment history, and interview questions and responses as per Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Without this there is no assurance that the staff employed were fit for their roles and appropriate employment checks had been completed, thereby placing residents at risk of harm. During the CQC inspection, records of this information for two staff members was missing.*

78. *On 22 May 2024 Mr Torabally, via his representative, admitted the charges in full and conceded impairment.*

Misconduct

79. *The Parties agree that Mr Torabally's acts and/or omissions as set out in the charges amount to misconduct.*

80. *The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:*

> *"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 [registered professional] in the particular circumstances".*

81. *As do the comments of Jackson J in Calhaem v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin), namely:*

> *"[Misconduct] connotes a serious breach which indicates that the [registered professional'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."

82. *Conduct or failings that put patients at risk of harm is usually a serious departure from standards; Mr Torabally breached multiple standards of the Code. It is acknowledged that not every breach of the Code will result in a finding of misconduct, however, the Parties agree that Mr Torabally's actions, and the resulting breaches of the Code, clearly amount to serious misconduct.*

83. *As the Registered Manager, Mr Torabally was entrusted to ensure the residents' wellbeing was protected. Unfortunately, there are several and wide-ranging instances of this not happening. Basic care principles were not followed and residents treatment needs were not reliably met.*

84. *Mr Torabally was responsible for leading improvements in the Home's clinical practice, however, when concerns were identified by the CQC and CCG, suitable action was not always taken to address the concerns, or the action taken was not sustained. Ultimately, the residents of the Home had to move as they faced significant risks.*

85. *The residents were particularly vulnerable due to their age and physical or cognitive conditions. Members of the public would expect that as a minimum, such residents are looked after in a safe and well-maintained environment. When this does not happen, this can damage the reputation of the profession and cause further unwarranted risk of harm, as members of the public may be reluctant to have their relatives who need additional support, reside in a care home.*

86. *Mr Torabally accepts that his failings are not only a serious departure from the professional standards and behaviour expected of a registered nurse, but risks causing harm to the public and risks bringing the nursing profession into disrepute.*

87. *For example, by failing to ensure that adequate care plans and/or risk assessments were in place, Mr Torabally did not safeguard the Home's residents from the risk of harm. The residents whose catheter and skin integrity were not monitored, were at risk*

of injury, pain and/or infection. In fact, the resident whose skin integrity was not adequately monitored, required admission to hospital because the Home "failed to provide [the resident, the] safe care and treatment they needed" and consequently their health was put "at serious risk of harm". When residents suffer harm that could have been avoided with proper care, this undermines trust and confidence in the profession.

88. *When considering the concerns with medication management and administration, the Parties agree that by failing to ensure controlled medication was signed by two staff members, as required, residents were at risk of receiving the incorrect dose and/or incorrect medication.*

89. *For the two residents who did not have up to date charts and/or daily checks on their transdermal patches, the Parties agree that this presented several risks. Daily checks were important as patches are prone to falling off or accidently being removed, and as the patches in this case administered pain relief, the residents could have experienced unnecessary pain, particularly if there were communication barriers. There was also a risk of overdose if a patch was not removed before another was applied. Further, if a patch was reapplied to the same site within 14 days, there was an increased risk of the resident suffering skin irritation.*

90. *The Parties agree that failing to comply with safeguarding requirements also risked harm to residents, as well as risked undermining the public's trust in the profession. This is particularly clear when considering that Mr Torabally failed to ensure the Home had effective systems to safeguard residents.*

91. *For example, Resident A's liberty could have been deprived unnecessarily, or they could have received improper treatment. Resident B was at risk of financial abuse and consequently a safeguarding referral was needed.*

92. *Risk of financial abuse is of particular concern in a care home setting, where residents care is financed and their personal money is often entrusted to others to manage. The Parties therefore agree that due to Mr Torabally's misconduct, members of the public*

could have concerns that their loved one's finances would be in danger if they were to reside in a care home, or that care homes' prioritise financial incentives over the safety and wellbeing of residents.

93. *Nurses occupy a position of privilege and trust in society and are expected to safeguard patients at all times. This is necessary to protect patients from harm and uphold the standards of the profession.*

94. *Mr Torabally acknowledges the risk of harm caused. He states:*

> *I do recognise that residents of Ashleigh Care Home did suffer harm, because in 2021 they had to be moved from their homes when the Home closed down. This would have been distressing and disorientating for them. I deeply regret that this happened.*

95. *The Parties agree that the failings in this case are wide ranging and involve multiple aspects of patient care. The failings are serious and fall far short of what is expected of a registered nurse. They amount to serious misconduct because it put the safety and wellbeing of residents of the Home at risk of harm.*

96. *Where the acts or omissions of a registered nurse are in question, what is expected/ proper in the circumstances (per Roylance) can be determined by reference to the NMC's Code of Conduct ('the Code').*

97. *At all relevant times, Mr Torabally was subject to the provisions of the Code. The Code sets out the professional standards that nurses must uphold. These are the standards that patients and members of the public expect from health professionals. The Parties agree the following provisions of the Code have been breached in this case:*

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

1.3 avoid making assumptions and recognise diversity and individual choice

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.5 respect, support and document a person's right to accept or refuse care and treatment

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

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

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

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

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

8 <u>Work co-operatively</u>

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

10 <u>Keep clear and accurate records relevant to your practice</u>

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

10.3 complete records accurately …, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.5 take all steps to make sure that records are kept securely

11 <u>Be accountable for your decisions to delegate tasks and duties to other people</u>

To achieve this, you must:

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

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

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

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

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

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

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 <u>Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations</u>

To achieve this, you must:

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.4 take all steps to keep medicines stored securely

19 <u>Be aware of, and reduce as far as possible, any potential for harm associated with your practice</u>

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures)

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

20 <u>Uphold the reputation of your profession at all times</u>

To achieve this, you must:

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

20.4 keep to the laws of the country in which you are practising

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

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

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

Impairment

98. *The Parties agree that Mr Torabally's fitness to practise is currently impaired by reason of his misconduct.*

99. *The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. A 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?"*

100. *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired. Answering this question involves a consideration of both the nature of the concern and the public interest.*

101. *The Parties agree that consideration of the nature of the concern involves looking at the factors set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J. The relevant questions are whether Mr Torabally:*

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 professions 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 professions.*

d) *Has in the past acted dishonestly and/or is liable to act dishonestly in the future?*

102. *The Parties agree that limbs a), b) and c) are engaged in this case. Considering each question in turn:*

Limb (a)

103. *As noted at paragraph 94 above, Mr Torabally accepts that the Home's residents suffered harm and, under his leadership, there were several issues that placed the Home's residents at unwarranted risk of harm.*

104. *It was Mr Torabally's responsibility to oversee the quality of care provided and identify any potential risks. There were risks with staffing, the storage of medication, and infection control, which had not been appropriately safeguarded against. Further, there were inadequate care plans/risk assessments and standards of record keeping.*

105. *Adequate records are vital for effective patient care. Incomplete or absent records e.g., care plans and risk assessments, pose an inherent risk to safe patient care, as it prevents those caring for the patients from establishing what care was previously provided, or what care is needed. Consequently, patients' needs may not be met. The risks were grave for Resident F, who was prescribed insulin. Due to there being no plan in place, there was a risk that staff would not know what action to take. Further, due to Resident F's blood glucose levels not always being recorded, it was impossible to tell if their glucose levels were in a safe range. This could have resulted in serious harm, including inducing a coma and/or death. Residents who did not always have their monthly weights recorded were at risk of malnutrition. Resident A and two other residents potentially had their rights breached because Mr Torabally did not obtain the necessary legal authority to deprive them of their liberty or provide covert treatment.*

106. *By not ensuring that staff were properly recruited and trained, patients were placed at risk of harm. They could have, e.g., been injured through inappropriate moving and handling technique. Furthermore, by not implementing and/or ensuring adherence to policies, or a clean and safe environment, residents were placed at risk of infection. Resident B was placed at risk of financial abuse because a risk assessment for staff to use her bank card and PIN was either not undertaken or documented.*

Limb (b)

107. *Registered professionals occupy a position of privilege and trust in society and are expected at all times to be professional. Members of the public must be able to trust registered professionals with their lives and the lives of their loved ones. It is agreed that by not providing effective leadership to ensure the residents were kept safe, Mr Torabally has brought the profession into disrepute. Upon learning of the Home's closure, members of the public may have lost confidence in the care system, and vulnerable residents and/or their loved ones may have been reluctant to access residential care as a result.*

Limb (c)

108. *All nurses must act first and foremost to care for and safeguard the public. Prioritisation of people, effective and safe practice, and professionalism are fundamental tenets of the Code. As a Registered Manager Mr Torabally placed patients at risk of harm and thereby breached these fundamental tenets.*

Public protection

109. *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 which the court set out as being 'highly relevant' to the determination of the question of current impairment, these are:*

i) Whether the conduct that led to the charge(s) is easily remediable.

ii) Whether it has been remedied.

iii) Whether it is highly unlikely to be repeated.

Limb (i)

110. *Having regard to the NMC's guidance 'Can the concern be addressed?' (FTP-14A), the Parties agree that the misconduct in this case is remediable. The failings in this*

case relate to discrete and easily identifiable areas of Mr Torabally's clinical practice, namely his clinical management and leadership skills. Further, a considerable period of time has passed since the incidents occurred i.e., at least 3 years.

Limb (ii)

111. *The Parties have considered the NMC guidance 'Has the concern been addressed?' (FTP-14b).*

Insight and remorse

112. *The Parties agree that Mr Torabally has demonstrated some insight. He accepts the substance of the regulatory concerns and acknowledges the risk of harm his conduct caused to patients.*

113. *In his case management form ('CMF') response, received by the NMC on 25 March 2024, Mr Torabally wrote:*

> *'…I accept that I should have properly ascertained what being a Registered Manager meant and then if I was not up to the job, I should have stepped down. Working at Vista and now for the NHS, I understand the importance of meticulous recording and good record keeping, follow protocols and pathways to always keep patients safe. I do recognise that residents at Ashleigh Nursing Home did suffer harm because back in 2021 they had to be moved to a place. This would have been distressing and disorientating for them. I deeply regret that this happened. I do accept accountability for the Home's failings and do not deflect blame. The system of registration and regulation of Care Homes is there to safeguard and protect the safety of patients. As a registered nurse, I must safeguard and protect patients. As a CQC Registered Manager at Ashleigh Nursing Home, it was my duty to ensure as well as I reasonably could, that the residents under our care were safe and that should have included properly overseeing and acting on the overall picture.*

I am a completely transformed person. I have learned from my mistakes and have worked incredibly hard since, to be a better person, a better nurse. I am remorseful of the way I handled certain situations and have learned a lot from my shortfalls…'

114. *Notwithstanding the above, it is agreed that Mr Torabally's level of insight requires further development. Whilst in his CMF response he stated that he would 'never make the same mistakes', has however not demonstrated that he fully appreciates what is required to ensure patients' wellbeing is protected nor the role he played in the concerns identified by the CQC and CCG. For example, with reference to Charge 2(c) i.e. staff were not implementing correct moving and handling techniques, Mr Torabally wrote:*

I trusted my staff to have used correct procedures at all times and cannot be held responsible if staff were not adhering to the correct techniques behind my back despite having had proper training. In the course of my meetings with staff they always assured me that they were complying with the best and safe practice requirements.

115. *This response does not take into account the fact that on more than one occasion the CCG identified that the moving and handling training for staff had expired, which was Mr Torabally's responsibility to arrange and ensure completion and adherence, and the impact this could have had on the staff's behaviour. It is also casts doubts on the effectiveness of Mr Torabally's leadership, if the Home's culture did not discourage staff from disregarding policies and procedures.*

116. *He has not demonstrated that he has reflected to identify why he behaved the way he did e.g., not implementing improvements as required, despite them being highlighted repeatedly by the CQC and CCG. He has not provided adequate detail of how he would act differently in the future, were he to ensure another Registered Manager role, to ensure the conduct outlined in the charges is not repeated.*

Remediation

117. *Following the Home's closure, Mr Torabally worked in care roles not requiring NMC registration until July 2023, when he was able to secure work as a band 5 nurse. He remains in this nursing position, which involves working with people with disabilities in a community hospital setting, with no reported significant issues.*

118. *Since 09 December 2021 Mr Torabally has been subject to an interim conditions of practice order ('ICOPO') and has worked without major incident. He has undertaken some relevant training, although it is unclear whether the training was completed online or face-to-face. The following training is relevant:*

    1. *(Clinical Mandatory) Hand Hygiene – 4 November 2023*
    2. *(Clinical Mandatory) Infection Prevention & Control Level 2 – 4 November 2023*
    3. *(Clinical Mandatory) Safety Interventions Foundation, Advanced and Emergency – 4 August 2023*
    4. *(Clinical Mandatory) Safeguarding Adults Level 2 – 4 July 2023*
    5. *(Core Mandatory) Health, Safety & Welfare – 4 August 2021*
    6. *(Core Mandatory) Infection Prevention & Control Level 1 – 4 August 2021*
    7. *(Core Mandatory) Moving & Handling Level 1 – 15 August 2021*
    8. *(Core Mandatory) Safeguarding Adults Level 1 – 15 August 2021*
    9. *(Role Essential) Clinical Risk Assessment – 2 October 2023*
    10. *(Core Mandatory) PPE Donning & Doffing – 30 August 2021*
    11. *(Role Essential) Record Keeping & Care Planning – 17 July 2023*
    12. *(Role Essential) Medicines Management – 24 January 2024*

13. *(Role Essential) Management and Prevention of Falls – 12 August 2023*
14. *(Clinical Mandatory) Safeguarding Adults Level 2 – 4 July 2023*
15. *Medication Awareness and Record Keeping for Care Workers – Level 2 – 23 November 2021*
16. *Manual Handling – Level 2 Parts 1 -6 – 23 November 2021*
17. *Safeguarding Vulnerable Adults (SOVA), Level 2 online training – Modules 1-3, including Deprivation of Liberty Safeguards and the Mental Capacity Act – 23 November 2021*
18. *Leadership skills – 3 April 2022*
19. *Administering Medication – 6 January 2022*
20. *Infection Control – 13 January 2022*
21. *Safer Recruitment – 20 April 2022*
22. *PPE in Healthcare – 21 April 2022*
23. *Assessing Needs – 23 March 2022*
24. *Care Planning – 18 April 2022*
25. *Safe Working Principles (Online Modules 1-9) – 22 November 2021*

119. *In his role as a Band 5 staff nurse, he has begun leading projects in his role as staff nurse, putting the training he has received into practice. He has also been entrusted to deliver training on hand hygiene to colleagues. and participating in developmental tasks related to the concerns.*

120. *In a report to the NMC dated 20 March 2024 his manager, [PRIVATE], Matron for Agnes Unit and Short Breaks, stated:*

'Mr Torabally continues to complete our monthly medication audit on the unit which includes checking all medication cupboards and clinical areas. Mr Torabally send out emails following the results from the audit and there has been an improvement in the unit's audit scores.

Mr Torabally has developed his lead role for IPC in the unit by completing the unit's monthly hand hygiene assessments on staff, developing training slides and sessions. Mr Torabally has delivered these training sessions during the units in house training sessions.

In the past five months Mr Torabally has continued to work hard, remaining within his conditions [of] practice but also developing his skills in the field of Learning Disabilities. At times this has been very challenging, and Mr Torabally would seek support, use the monthly meetings to reflect on situations and develop his learning from these challenges. We have jointly identified Mr Torabally as meeting the criteria to complete the BILD positive behaviours support coaching course which will be a four day programme with a project. Mr Torabally will commence on this training in June 2024.'

121. *Despite the positive steps Mr Torabally has undertaken to remediate the issues of concern, the Parties agree that they are yet to be fully remediated.*

122. *The concerns with Mr Torabally's conduct took place over a significant period of six years and continued despite him being aware of the needs for improvement identified by the CQC and other authorities. It is agreed that his current position as a Band 5 nurse does not provide him with the same level of managerial responsibility as he held as a Registered Manager. Furthermore, he has only been in his current role for approximately a year. He has thus been unable to demonstrate that the issues would not reoccur were he to find himself in a similar position of leadership and authority, without supervision.*

Limb (iii)

123. *The Parties have considered the NMC guidance 'Is it highly unlikely that the conduct will be repeated?' (FTP-14c).*

124. *Although Mr Torabally has an otherwise positive professional record and has engaged with the NMC's processes, it is agreed that a risk of repetition remains. There is no evidence to suggest that the behaviour demonstrated Mr Torabally arose in a unique set of circumstances. As mentioned above, his conduct took place over six years and continued even though he was aware of what action he needed to take to address the concerns. His insight needs to be developed further and he has not practiced in a similar environment or capacity since 2021.*

125. *The Parties agree that a finding of impairment is therefore necessary on public protection grounds in the absence of full insight or remediation, and with the ongoing risk of repetition.*

Public interest

126. *The Parties agree that a finding of impairment is necessary on public interest grounds.*

127. *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."*

128. *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.*

129. *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 has not been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.*

130. *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. The professional standards that registered nurses must uphold, apply whether the nurse is providing direct care to patients, or is bringing their professional knowledge to bear in other roles, such as in leadership positions.*

131. *The Parties agree that a member of the public appraised of the facts, would be shocked to hear that a registered nurse, in a position of leadership as a CQC Registered Manager for care homes, repeatedly placed residents at unwarranted risk of harm by e.g., not taking steps to ensure that residents were appropriately risk assessed for medical conditions, legally deprived of their liberty, or protected from financial abuse. As such, the need to protect the wider public interest calls for a finding of impairment to declare and uphold proper standards of the profession and maintain trust and confidence in the profession and the NMC as its regulator. Without a finding of impairment, public confidence in the profession, and the regulator, would be seriously undermined.*

Sanction

132. *Taking into account the NMC Sanctions Guidance, the Parties agree the following sanction is proportionate:* ***12-months conditions of practice order with review.***

133. *Any sanction imposed must do no more than is necessary to meet the public interest and must be balanced against Mr Torabally's right to practice in his chosen career. To achieve this the panel is invited to consider each sanction in ascending order.*

134. *In their contemplation the Parties have considered the following aggravating and mitigating factors:*

Aggravating factors:

- *Pattern of misconduct over a significant period i.e., 6 years*
- *Some of the residents placed at risk were vulnerable due to their lack of mental capacity, and others were potentially vulnerable due to their age.*

Mitigating factors:

- *Evidence of developing, albeit not full, insight into the concerns.*
- *Evidence of training in attempt to address the concerns.*
- *Reported lack of support from the Registered Provider*
- *The Home was frequently short-staffed*

135. *With regard to the NMC's sanctions guidance, the following aspects have led the Parties to this conclusion:*

135.1. ***Taking no further action*** *or imposing a* ***caution order*** *would be wholly inappropriate as they would not reflect the seriousness of the misconduct, nor would they protect the public or maintain the public confidence in the profession.*

135.2. *A* ***conditions of practice order*** *is the appropriate order. The Guidance (SAN-3c) says that a conditions of practice order is appropriate when the concerns can easily be remediated and when conditions can be put in place that will be sufficient to protect the public and address the areas of concern to uphold public confidence. The Parties agree that that there is no evidence of harmful deep-seated personality or attitudinal problems; there are identifiable areas of Mr Torabally's practice in need of assessment and/or retraining; Mr Torabally has shown a willingness and has positively responded to retraining, patients will not be put in danger either directly or indirectly as a result of conditions, the*

conditions will protect patients during the period they are in force, and conditions can be created that can be monitored and assessed.

135.3. 12 months will afford Mr Torabally the opportunity to further develop his insight and undertake additional targeted training. A review before expiry would afford the NMC the opportunity to ensure that the misconduct has been sufficiently remediated.

135.4. The Parties recommend the following conditions:

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.'

1. *At any time when working in a management and/or leadership position where you are involved in the management and/or leadership of nurses, healthcare professionals or the provision of care:*

   a) *You must work with your line manager, and clinical supervisor to create a personal development plan (PDP). Your PDP must address the concerns about overseeing the quality of care provided by members of staff.*

   b) *You must send your NMC case officer a copy of your PDP fourteen days before any review hearing. This report must show your progress towards achieving the aims set out in your PDP.*

2. *You must keep the NMC informed about anywhere you are working by:*

   a) *Telling your NMC case officer within seven days of accepting or leaving any employment.*

   b) *Giving your NMC case officer your employer's contact details.*

3. *You must keep the NMC informed about anywhere you are studying by:*

a) *Telling your NMC case officer within seven days of accepting any course of study.*

b) *Giving your NMC case officer the name and contact details of the organisation offering that course of study.*

4. *You must immediately give a copy of these conditions to:*

a) *Any organisation or person you work for.*

b) *Any agency you apply to or are registered with for work.*

c) *Any employers you apply to for work (at the time of application).*

d) *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study*

5. *You must tell your NMC case officer, within seven days of your becoming aware of:*

a) *Any clinical incident you are involved in.*

b) *Any investigation started against you.*

c) *Any disciplinary proceedings taken against you.*

6. *You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:*

a) *Any current or future employer.*

b) *Any educational establishment.*

c) *Any other person(s) involved in your retraining and/or supervision required by these conditions*

*135.5. A **suspension order** would be inappropriate. With regard to the NMC guidance (SAN-3d), the Parties agree that the misconduct is not fundamentally incompatible with continued registration, nor does it call for temporary removal from the register. Although the concerns with Mr Torabally's practice are wide-ranging and of a serious nature, the misconduct can be addressed through a conditions of practice order. There is no evidence of harmful deep-seated personality or attitudinal problems. Suspension would thus be disproportionate.*

*135.6. A **striking-off order** would be inappropriate. It is agreed that being proportionate calls for finding a fair balance between Mr Torabally's rights and the NMC's overarching objective of public protection. Having reviewed the key considerations set out in the NMC guidance at SAN-3e, the Parties agree that a striking-off order is not the only sanction that would protect patients and members of the public and maintain professional standards.*

Maker of allegation comments

136. *The CQC were invited to comment on the proposals of the CPD agreement. In their comments dated 30 August 2024, they state:*

> *'Thank you for providing an update on the scheduled hearing and sharing Sheik Mohamed Reshad Ali Osman Torabally's response and accepting the concerns raised about their fitness to practise.*
>
> *I support the provisional agreement to apply a conditions of practice order (12 months) on Sheik Mohamed Reshad Ali Osman Torabally.'*

Interim order

137. *It is agreed that an interim order is required in this case for the protection of the public and otherwise in the public interest for the reasons given above. The interim order should be for a period of 18 months in the event that Mr Torabally seeks to appeal the panel's decision. The interim order should take the form of an interim conditions of practice order.*

138. *The interim conditions of practice should be in the same terms as the substantive conditions of practice above.*

139. *The Parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The Parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.'*

Here ends the provisional Consensual Panel Determination (CPD) agreement between the NMC and you. The provisional CPD agreement was signed by you on 9 October 2024 and the NMC on 10 October 2024.

Decision and reasons on the CPD

The panel decided to amend the conditions of practice of the CPD.

Mr Badruddin on behalf of the Nursing and Midwifery Council (NMC) confirmed that both parties have signed the CPD agreement which is included in the master bundle the panel have read. He referred the panel to the provisional CPD agreement. He submitted that the suggested conditions of practice order would be sufficient to manage the risk that underlies the charges.

Mr Badruddin informed the panel that both you and your representative Mr Torabally, are available to join should the panel have any questions or need any clarification.

The panel heard and accepted the legal assessor's advice, who referred the panel to the NMC guidance DMA-2b on 'Consensual Panel Determinations' (as updated 27/02/2024) He reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and you. Further, the panel should consider

whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel had regard to the NMC guidance on *'Consensual Panel Determinations'* and to the NMC *'Sanctions Guidance'* (SG). The panel noted its powers, namely that it could accept, amend or outright reject the provisional CPD agreement reached between you and the NMC. Further, the panel was mindful that it should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that you admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of your admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on misconduct and current impairment

The panel then went on to consider whether your fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and you, the panel has exercised its own independent judgement in reaching its decision on impairment.

The panel noted that you agree that you are currently impaired by reason of your misconduct. The panel accept your admission and determined that you are currently impaired due to a lack of any significant progress with regard to insight and practice and there remains a risk of repetition.

In respect of misconduct, the panel determined that the charges are serious, wide ranging and occurred on a number of occasions. The endorsed paragraph 97 of the provisional CPD, that you were in breach of the provisions of the Code as identified.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

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

The panel also had regard to the test set out by Dame Janet Smith in the Fifth Shipman Report, approved in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) by Cox J;

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 professions 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 professions; and/or

d. …

The panel found limbs a, b and c engaged in this case.

The took account of paragraph 87 of the CPD, which states:

> *'The residents whose catheter and skin integrity were not monitored, were at risk of injury, pain and/or infection. In fact, the resident whose skin integrity was not adequately monitored, required admission to hospital because the Home "failed to provide [the resident, the] safe care and treatment they needed" and consequently*

their health was put "at serious risk of harm'.

The panel determined that patients were not only put at risk of harm, but there was actual harm as the resident needed hospitalisation. The panel considered that your actions had a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute.

The panel considered that you have provided some insight, however it is not yet fully developed, The panel took account of your statement on paragraph 113 from your Case Management Form ('CMF') response, received by the NMC on 25 March 2024, in which you state that the residents would have been distressed and upset as a result of being moved due to what happened at the Home, but not about the impact of the events which took place.

The panel also noted at paragraph 114 of the CPD agreement, you state:

'...I trusted my staff to have used correct procedures at all times and cannot be held responsible if staff were not adhering to the correct techniques behind my back despite having had proper training...'

The panel determined that you appear to be blaming others, rather than having insight into how your leadership failed to provide safeguards and quality assurance systems that may have prevented adverse events. You have not provided any reflection on how you might behave in future, nor have you apologised for your misconduct.

The panel considered whether your misconduct is capable of remediation. The panel had regard to the recent training you have undertaken as well as the positive testimonial provided at paragraph 120 of the CPD agreement. The panel was of the view that the training, although fairly extensive, was mandatory training required to fulfil your current working role, and not over and above what was required. The panel considered that there is a risk of repetition given the wide-ranging nature of your failures over a protracted period of time. The panel acknowledge that the opportunity for you to develop further leadership skills has not yet been presented to you, however it determined that you are at

the early stages of remediation and a lot more needs to be done in order for you to no longer be impaired.

As a consequence, you have been unable to demonstrate strengthened practice. The panel therefore determined that there is a risk of repetition of the misconduct and a consequent risk of harm to patients. Accordingly, the panel found that your fitness to practise is currently impaired on public protection grounds.

The panel determined that a finding of impairment was required on public interest grounds. It considered that given the public protection issues identified and the wide ranging, repeated and fundamental nature of the misconduct a member of the public would be surprised to hear that a registered nurse was entitled to practise without restriction in the circumstances. The panel determined that public confidence in the profession and the regulator would be undermined if a finding of impairment was not made in these circumstances and proper standards of professional conduct would not be upheld.

The panel determined that your fitness to practise is currently impaired on both public protection and public interest grounds.

Decision and reasons on sanction

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

The panel considered the following to be aggravating features:

- *Pattern of misconduct over a significant period i.e., 6 years*

- *Some of the residents placed at risk were vulnerable due to their lack of mental capacity, and others were potentially vulnerable due to their age.*
- *Lack of any developed insight into failings*
- *Wide-ranging elements of misconduct*

The panel also took into account the following mitigating features:

- *Evidence of developing, albeit not full, insight into the concerns*
- *Positive testimonial from your current line manager*

The panel did not consider the following to be mitigating features

- *'Reported lack of support from the Registered Provider*
- *The Home was frequently short-staffed'*

The panel considered the context of working just after the Covid-19 pandemic. The panel noted that nothing has been presented to it in relation to the culture and / or working practices affecting the staffing levels at the Home during this time.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that you 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *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 determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel was satisfied that a conditions of practice order are the proportionate sanction to address the concerns identified, protect the public and provide a workable and measurable means to keep you in practice.

The panel accepted that you would be willing to comply with conditions of practice.

The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

Balancing all of these factors, the panel agreed with the CPD that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel considered carefully whether to impose a suspension order, however considered it would be disproportionate and that a conditions of practice order would be the more fair and reasonable response in the circumstances of your case.

During the panel's deliberations, the panel suggested three additional conditions of practice, as follows:

> *1. You must not work as a manager of a care home.*
>
> *2. You must have meetings with your line manager at least every four weeks to discuss ways in which you are applying quality standards to your work and the work of other team members, and how you meet clinical governance requirements when implementing any new initiatives.*
>
> *3. You must provide a reflective statement six weeks prior to your review detailing the impact of your misconduct upon residents and families and the implications for public confidence in the profession.*

The parties were therefore invited back into the hearing. Mr Badruddin submitted that he was in agreement with all of the suggested additional conditions. Mr Torabally submitted that he was in agreement with all of the suggested additions in principle, however in relation to condition 2, he requested that the frequency of meetings be changed to 12 weeks to allow you to prepare what you have learned in order to be coherent when you meet with your manager. However, he stated that he would comply with any decision on frequency the panel made.

The panel determined that a frequency of 12 weeks is not enough due to the seriousness of the allegations and the facts found proved.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel agreed with the CPD that the following conditions are appropriate and proportionate in this case:

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.'

1. You must not work as a manager of a care home.

2. You must have meetings with your line manager at least every four weeks to discuss ways in which you are applying quality standards to your work and the work of other team members, and how you meet clinical governance requirements when implementing any new initiatives.

3. You must provide a reflective statement six weeks prior to your review detailing the impact of your misconduct upon residents and families and the implications for public confidence in the profession.

4. *You must work with your line manager, and clinical supervisor to create a personal development plan (PDP). Your PDP must address the concerns about overseeing the quality of care provided by members of staff.*

5. *You must send your NMC case officer a copy of your PDP fourteen days before any review hearing. This report must show your progress towards achieving the aims set out in your PDP.*

6. *You must keep the NMC informed about anywhere you are working by:*

   a) *Telling your NMC case officer within seven days of accepting or leaving any employment.*

   b) *Giving your NMC case officer your employer's contact details.*

7. *You must keep the NMC informed about anywhere you are studying by:*

   a) *Telling your NMC case officer within seven days of accepting any course of study.*

   b) *Giving your NMC case officer the name and contact details of the organisation offering that course of study.*

8. *You must immediately give a copy of these conditions to:*

   a) *Any organisation or person you work for.*

   b) *Any agency you apply to or are registered with for work.*

   c) *Any employers you apply to for work (at the time of application).*

   d) *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study*

9. *You must tell your NMC case officer, within seven days of your becoming aware of:*

   a) *Any clinical incident you are involved in.*

   b) *Any investigation started against you.*

c) *Any disciplinary proceedings taken against you.*

10. *You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:*

a) *Any current or future employer.*

b) *Any educational establishment.*

c) *Any other person(s) involved in your retraining and/or supervision required by these conditions*

The period of this order is for 12 months.

Before the end of the period of the order, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement with the NMC and attendance at a future review
- Details of any training and education completed since the imposition of your substantive conditions of practice order
- Updated testimonials

Interim conditions of practice order

It is agreed that an interim order is required in this case for the protection of the public and otherwise in the public interest for the reasons given above. The interim order should be

for a period of 18 months in the event that you seek to appeal the panel's decision. The interim order should take the form of an interim conditions of practice order.

The interim conditions of practice order will be in the same terms as the substantive conditions of practice order.

This will be confirmed to you in writing.

That concludes this determination.