Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 17 June 2024 – Tuesday 02 July 2024
Friday 13 September 2024

Virtual Hearing

Name of Registrant:	Uju Delia Emekekwue
NMC PIN	96J0508E
Part(s) of the register:	Nurses part of the register Sub part 1 RNMH: Mental health nurse, level 1 (4 October 1999)
Relevant Location:	England, London
Type of case:	Misconduct
Panel members:	Adrian Smith (Chair, Lay member) Rosalyn Mloyi (Registrant member) Rachel Barber (Lay member)
Legal Assessor:	Graeme Sampson
Hearings Coordinator:	Hazel Ahmet
Nursing and Midwifery Council:	Represented by Shoba Aziz/Hazel McGuinness, NMC Case Presenter
Ms Emekekwue:	Present and unrepresented at the hearing
Facts proved:	Charges 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.11, 1.12, 1.13, 1.14, 1.15, 2.1, 2.2.1, 2.2.2, 2.4, 2.5, 3, 7, 8.
Facts not proved:	Charges 1.10, 2.3, 4, 5, 6.
Fitness to practise:	Impaired
Sanction:	Suspension Order (3 months)

Interim order:	Interim Suspension Order (18 months)

Details of charge

‘That you a registered nurse

1. Whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:

1.1 Access, Security and Privacy
1.2 The Home Environment
1.3 Fire Safety
1.4 Health and Safety
1.5 Infection Control and cleaning
1.6 Care Folders
1.7 Health
1.8 Medication
1.9 Nutrition
1.10 Activities
1.11 Finance
1.12 Legal protection
1.13 Staffing
1.14 record keeping
1.15 care documentation

2. Did not ensure that Resident A’s care had been managed adequately in that you
2.1 did not ensure that they had access to the community
2.2 did not ensure that they were able to access one or more of the following areas of the facility independently
2.2.1 Garden
2.2.2 En suite shower room
2.3 Did not have regard to their wishes with regards to the use of CCTV at the Home

2.4 Did not ensure that complete records were kept in relation to care and support that had been provided to Resident A
2.5 On becoming aware that the Resident was assessed for use of a wheelchair in October 2021, did not chase the outcome of this referral adequately until June 2022.

3. On or around 9 March 2021 informed Person A who was from the Royal Borough of Greenwich that the CQC had passed the service as eligible as a Supported Living Service which was inaccurate.

4. Your actions at charge 3 were dishonest in that you sought to create the impression that your service was eligible as a supported living service when you knew it was not.

5. On 16 June 2021 when asked by person A as to why the service was showing up as a residential care home responded that 'it is definitely to be supported accommodation' which you knew was inaccurate.

6. Your actions at charge 5 were dishonest in that you maintained that you were registered as supported living services when you knew you were not.

7. On 24 August 2022 sent an email to the NMC stating that you had completed another application in July 2021 to the CQC adding 'personal care' as a regulated activity when you had not.

8. Your actions at charge 7 were dishonest in that you sought to create the impression that you had submitted another application to the CQC dated 19 July 2021 when you knew that you had not.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mrs Aziz under Rule 31 to allow the written statement of Witness 6, an NMC case worker, into evidence. Witness 6 was not present at this hearing and, Mrs Aziz submitted that the NMC has chosen not to call him as a witness as his statement is short and is supported by email. The NMC determined that it would be sufficient for Witness 6's statement to merely be read into the record.

Mrs Aziz submitted that this hearsay evidence is that of a conversation via email between Witness 6 and you. She submitted that the appropriate redactions have been made to this evidence, that no unfairness would occur to you if it were to be presented, and no third parties are involved or mentioned. Further, Mrs Aziz submitted that this evidence supports some of the charges which have been put forward.

Mrs Aziz submitted that the NMC had provided you with sufficient notice in order for you to make an objection to this hearsay evidence being presented, which you did not.

The panel heard a further application made by Mrs Aziz under Rule 31 to allow the written statement of Witness 7. She submitted that the NMC has tried to secure the attendance of this witness at this hearing multiple times, however, he has requested not to be contacted and has stated that he would not be attending to give evidence, even if he were contacted over a phone call. Mrs Azis submitted that this witness stated that he has nothing further to add and does not want to be part of these proceedings any longer.

Mrs Aziz submitted that the statement of Witness 7 is directly relevant to support the charges against you, and it is imperative that this statement be put forward and read by the panel. She further added that, due to the inability for the panel to cross examine this witness, it is their prerogative as to how much weight is placed on this evidence.

Mrs Aziz further submitted that there has been no objection from you to this witness statement being admitted.

You submitted that you do not object to either of these witness statements being placed before the panel for consideration.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is *'fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to Witness 6, and Witness 7 serious consideration. The panel noted that both of these witness statements had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* and signed by them.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 6 and Witness 7 to that of a written statement.

The panel noted that you had been provided with a copy of Witness 6's and Witness 7's statements and that you have not objected to these statements being put forward before the panel as evidence.

The panel considered the potential unfairness towards you in that you would not have the opportunity to cross-examine these witnesses. However, there was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 6 and Witness 7 into evidence but would give what it deemed appropriate weight to this evidence once the panel had heard and evaluated all the evidence before it.

Background

On 1 August 2022, the NMC received a referral from the Care Quality Commission (‘CQC’). The CQC explained that you [were] the registered manager for the location Birkdale Road (the Home), provided by a company called Medoc Healthcare Ltd which [was] registered as a care home with the CQC. In addition, you [had] registered the Home with Greenwich Clinical Commissioning Group (Greenwich CCG). The Home [provided] services including nursing services for up to three adults with mental health needs and was established on 16 March 2021.

In May 2022, Greenwich CCG completed a monitoring visit and identified significant concerns with the quality and safety of the care services being provided to the single resident. This led to a CQC inspection which found further concerns about the safety of the Home and your management of the Home.

Decision and reasons on facts

At the outset of the hearing, you informed the panel that you made full admissions to charges 1.2, 1.5, 1.7, 1.9, 1.11, 2.1, 2.2.2, 2.4, 2.5, 3 and 7.

The panel therefore finds charges 1.2, 1.5, 1.7, 1.9, 1.11, 2.1, 2.2.2, 2.4, 2.5, 3 and 7 proved in their entirety, by way of your admissions.

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- **Witness 1:** Registration Inspector for the Operations Group London and East of England Network Team 4, Care Quality Commission (CQC)

- **Witness 2:** Quality Assurance Manager of the Integrated Commissioning Unit for health and Adult services, Royal Borough of Greenwich (LBG)

- **Witness 3:** Registration Inspector, CQC

- **Witness 4:** Commercial and Operational Director, Inspire Community Trust (inc. Greenwich Wheelchair Services)

- **Witness 5:** Quality Assurance Officer, LBG

- **Witness 8:** Your witness.

The panel also heard evidence from you under oath, and your witness, Witness 8.

NMC's Submissions on Facts

Mrs Aziz submitted that it is the duty of the NMC to prove the charges on the balance of probabilities and requested that the panel has regard to the evidence matrix provided.

Mrs Aziz submitted that you had made an application for your property to be listed as a Supported Living Service ('SLS') and that Witness 3 had conducted a telephone assessment with you which was long and in-depth. Mrs Aziz submitted that you had stated

you wanted to apply as an SLS, but your property did not fit the criteria. Witness 3 had approved the application as an accommodation with nursing and personal care, to which you stated that you did not read the certificate and did not understand this.

Mrs Aziz submitted that The NMC's submission is that you did read the certificate, and that you were aware that what you had applied for was not an SLS, the ineligible service you believed to have been registered for. Mrs Aziz submitted that there was documentation to show that you were registered by Royal Borough of Greenwich as an SLS rather than accommodation with nursing and personal care. She did highlight that you acknowledged you failed to look at the certificate, and that you should have done so when Witness 3 told you that your registration was approved.

Mrs Aziz submitted that despite having told the London Borough of Greenwich that your intention was to provide a supported living service in October of 2021, you accepted a Complex Nursing Placement in May 2022. Mrs Aziz submitted that this speaks to your dishonesty.

Mrs Aziz gave details on how you were unable to provide a sufficient care plan for Resident A when Person A's visit took place. She submitted that Resident A required certain care needs which were unmet. She submitted that there was no care plan in relation to Resident A's eating, or hygiene. She submitted that Resident A had limited ability to exit the building as there were no ramps, even though you had stated that there were plans for ramps to be installed. She submitted that Resident A had not been able to have a wash for the six months that he had lived at the Home Residence. Further, she submitted that no activities were put in place to promote Resident A's independent living skills. Mrs Aziz submitted that Resident A required 24-hour nursing needs, but you were the only nurse employed at the home.

Mrs Aziz submitted that you have demonstrated poor leadership and management, resulting in risk of harm for Resident A alongside having failed to act on Resident A's needs. She further stated that the NMC submit that your actions show flagrant lack of

competence and a failure of safeguarding in relation to Resident A through lack of accurate record keeping and failure to adhere to policies.

Mrs Aziz acknowledged that you have fully admitted to some of the charges and partly admitted other charges, whilst justifying other actions through hindsight. She noted that this is not sufficient as an excuse, however, as it was your duty to check the accuracy of the registration of your service. She submitted that you provided false information to London Borough of Greenwich in terms of informing them that you were registered with the CQC as an SLS. Mrs Aziz submitted that your actions were dishonest on the basis that, at the time in which you had provided this information, this was not the case.

Mrs Aziz submitted that the application for registration with the CQC had been changed from an SLS to a Nursing Home, which you claim to have been unaware of. The NMC submit that this is not true, and that you were both aware, and understood the differences between the two certifications.

Mrs Aziz submitted that the panel has to consider very carefully the evidence before. In relation to Charges 7 and 8, she submitted that the documentary evidence that has been outlined provides a sufficient foundation to show that you had acted dishonestly and that you did not submit an application to change your registration from a care home to an SLS in July 2021, as you claimed to the NMC in August 2022.

Mrs Aziz submitted that the panel can be satisfied that testimonies of the witnesses who have given evidence in this case, are accurate. She further stated that the NMC can be satisfied on the balance of probabilities that the allegations occurred as set out in the charges and caused a risk to the public and the integrity of the profession as a result of your lack of competence and misconduct.

Mrs Emekekwue's Submissions on Facts

You submitted that you understand the seriousness of the allegations made against you by the NMC and re-instated your commitment to the highest standards of NMC practice.

In relation to Charge 1.1, you submitted that you partly accept this charge, [PRIVATE]

In relation to Charge 1.2, you submitted that you accept this charge partly, however, noted that you did make plans to install a ramp from the kitchen door into the back garden. You submitted that, unfortunately, before this was able to occur, Resident A was admitted to hospital. You stated that you were not commissioned to be a Care Home but were actually commissioned by the London Borough of Greenwich to be a Supported Living Service.

In relation to Charge 1.3, you provided information regarding the fire drills and evacuation procedures to the panel, to show that fire safety issues were addressed within your property.

In relation to Charge 1.4, you recounted that the NMC had mentioned that Person A did not see any incident reports or documentation when he had attended the property; you submitted that this was due to the fact that when he had attended the property, the internet network was not working. You submitted that all relevant documentations were in place prior to Person A visiting on 6 May 2022, and that all concerns that were raised by Person A were followed with immediate steps to resolve them; for example, you installed locks to the cupboards containing cleaning products.

In relation to Charge 1.6, you submit that you partly accept this charge, but that Resident A's district nurses' folder was always kept in the resident's room and never removed from this room.

In relation to Charge 1.7, you submitted that you accept this charge. You submitted that the home did not have the correct washroom facilities to accommodate Resident A, further stating that this fact only became apparent once you had already undertaken his initial assessments and accepted him into the home. Initially, you stated, he had met the criteria

required to be accommodated by a Supported Living Service, in terms of his diagnosis of mental illness and learning disability. You submitted that Resident A's other physical health issues were not as apparent until he had arrived at the premises. You submitted that Resident A did not like water to touch his body, and although a shower was provided, he did not want to use it. You submitted that you were required to find a way to maintain and ensure that Resident A was well groomed and supported.

In relation to Charge 2.2.1, you submitted that Person A *'did not concentrate'* during his visit, and he was not referring to the front garden, but rather the back garden when he had stated that there were *'no steps'.* You submitted that there is easy access to both gardens at the front and the back of the property.

In relation to Charge 3, you submitted that you accept this charge, but that you genuinely believed that your service had been passed by CQC, as an eligible Supported Living Service, and not a care home.

In relation to Charge 4, you denied this charge, submitting that you had no dishonest intentions. You submitted that the application form was long and not easy to understand, and that you did not have any intention of providing full nursing care, as you are qualified as a mental health nurse, only. You submitted that during your assessment, Witness 3 was incredibly suggestive, and had told you *'You can give medication […] you can do this, you can that'*. You submitted that you trusted Witness 3 for his expertise. Witness 3 confirmed that he changed your application internally after your initial assessment with him, and also confirmed that he did not inform you of this change, neither through email nor a phone call. You submitted therefore that he made these changes to your original application without your consent.

You submitted that you appreciate that it was your responsibility to fully research and understand the application form and to check the certification when it was granted and be aware that it was not for a supported living service.

You submitted that following the initial visit from the London Borough of Greenwich on 6 May, you were *‘quite mortified’* to realize that you had not fully comprehended the scale and the complexity of the responsibility you had taken on in setting up and managing the home, or how different it was to your day job as an experienced and competent mental health nurse. You submitted that following the initial visit, you began to work on putting various measures and changes in place immediately and had already rectified many of the issues identified. Further, you attended the action plan meeting organized by London Borough of Greenwich.

In relation to Charge 8, you submitted that you had prepared another application to be sent through to the CQC dated 19 July 2021 but had sent this through to an experienced friend in order to have it proof-read. You submitted that you had incorrectly presumed that this friend would submit your completed form on your behalf, which she did not do. You submitted the following:

> *‘I only realized my error in making this assumption when this was queried, and I later learned that CQC had not received this application. I appreciate that it was my responsibility to submit the application or to ensure you got the application was submitted and I am extremely sorry for my failure.’*

You submitted that you set up your facility with the best of intentions, but accepted that you were naïve and inexperienced, and therefore ill equipped to set up or lead such a facility. You submitted that you were approved to provide a home for residents during the Covid-19 pandemic.

You apologised profusely to CCG, the London Borough of Greenwich, the CQC, and the NMC. You assured the panel and the NMC that you would never intentionally do anything to put the health and wellbeing of any patient at risk. You are fully aware that as a registered nurse it is your responsibility to ensure you fully understand and comply with all requirements for setting up leading and managing any care facility. You stated that you are remorseful for failing to have done this.

You submitted that you have no intention to ever attempt to set up, lead, manage, or run any care facility in the future and simply wish to continue your work as a mental health nurse. You submitted that you have continued to strive to develop and maintain your knowledge and skills by taking on training opportunities available to you. In particular, you highlighted that you have completed training in Professionalism and Professional Standards for Nurses and Midwives, Patient Safety and Safeguarding Adults.

[PRIVATE]

You submitted that you are passionate about being able to continue practicing, in order to not only provide for your family, but also to care for your patients.

You submitted that you still love being a nurse, and sincerely hope to continue to work as a nurse to care for, support and advocate on behalf of people who are less able to do so for themselves

Panel's decision on facts

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

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

Charge 1.1)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:

> 1.1) Access, Security and Privacy”

The panel took into consideration the statement of Person A, noting that it reflected the findings of both him and a colleague who was present at the visit on 6 May 2022. The panel noted that Person A and colleague were allowed into your property without being asked for any form of identification and neither were they questioned during the Covid-19 period about if they were safe to enter.

[PRIVATE]

However, although you made a partial admission, it was identified that it was not in dispute that access, security and privacy in the home was compromised, rather, you sought to give reasons as to why it occurred.

Therefore, the panel found that this charge is found proved.

Charge 1.2)

> “That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.2) The Home Environment”

This charge is admitted and therefore found proved.

Charge 1.3)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.3) Fire Safety"

The panel noted that you deny this charge. The panel determined that it preferred the evidence of Person A in relation to this charge. It noted that you admitted that you had only undergone one single fire drill at your property in December 2021, which the panel considered to be insufficient, particularly during the period of 8 months in which Resident A was in your care. The panel acknowledge that you did send the fire drill policies and emergency evacuation procedure documents to the panel, but noted nevertheless that these were not seen by Person A on their visit on 6 May 2022.

Therefore, the panel found that this charge is found proved.

Charge 1.4)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.4) Health and Safety"

The panel determined that in relation to this charge, it was not persuaded by your argument that you had undergone relevant training in food hygiene during an infection control and prevention course, as this does not involve everything that is covered in the specific Food Hygiene Course, such as the temperature of food, the dating of food, etc.

The panel noted that at the London Borough of Greenwich visit on 6 May 2022, Person A noted several trip hazards, and that there was no CO2 detector in place and although you had confirmed that this was rectified prior to the second visit on 16 May, the panel determined that on the first visit, it is a fact that adequate health and safety measures were not in place.

Therefore, the panel found that this charge is found proved.

Charge 1.5)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.5) Infection Control and Cleaning"

This charge is admitted and therefore found proved.

Charge 1.6)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.6) Care Folders"

The panel noted that you made partial admissions to this charge. The panel noted that you stated that the relevant documentation was present on a digital *'Cloud Drive'* but was no physical folder. The panel acknowledged that there was a folder in the home that

belonged to the district nurses, but that this is not sufficient in terms of care documentation. The panel was not convinced by the explanation of documents being kept in word format on a cloud drive or that, if this was the case, that this would have enabled staff to have fully and easily been able to access Resident A’s care plan in order to deliver effective care. The panel also noted, as Resident A was the sole resident, this task should not have been an onerous one and his care folder should have been correctly and adequately completed.

Therefore, the panel found that this charge is found proved.

Charge 1.7)

> “That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.7) Health”

This charge is admitted and therefore found proved.

Charge 1.8)

> “That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.8) Medication”

The panel noted that you made partial admissions to this charge. The panel took into account the evidence of Person A, and the evidence provided by the NMC in relation to your management of medications. The panel noted that you did provide reasons as to why certain medications were not stored correctly but determined that these were insufficient to justify such poor management of medication. You stated that Resident A's next of Kin had brought medications to your property the day before and they had been left in a bag ready to be sent to the pharmacy for disposal. You said the bag had been sealed with a secure tie and that it was behind a locked door of the room it was in. You said there was no where to store the medication, however, the panel noted that in your email to the Witness 2 at the London Borough of Greenwich on 9 June 2022, you said the medication was in a locked cupboard. You denied that the medication was out of date, however, the panel noted that you also stated that it was medication that Resident A was no longer prescribed and had not used for over a year. The panel therefore identified inconsistencies within your explanation, and consequently it preferred both the evidence of Person A, and the evidence and explanation provided by the NMC, in relation to this charge.

Therefore, the panel found that this charge is found proved.

Charge 1.9)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.9) Nutrition"

This charge is admitted and therefore found proved.

Charge 1.10)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.10) Activities"

The panel determined that it was not possible to find sufficient evidence to find this charge proved. It noted the positive evidence of Witness 7, in which he identified an improvement in Resident A's mental health after attending your property. The panel was of the view that the issues raised by the referrer seemed to relate more to the fact that the activities that were taking place within the property were not recorded, or timetabled. Nonetheless, the panel did not find evidence that the activities did not take place at all. It noted your evidence that your property provided the resident with boardgames to play in the garden, as well as musical instruments in Resident A's room. At the time Person A and colleague visited the home, they observed staff engaging Resident A in activities.

Therefore, the panel found that this charge is found NOT proved.

Charge 1.11)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.11) Finance"

This charge is admitted and therefore found proved.

Charge 1.12)

> “That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.12) Legal Protection”

The panel noted that you have made partial admissions to this charge. It took into account the Statement of Person A, as well as the discussion which took place between Person A and yourself under cross examination. In relation to this charge, you submitted that you had a clear understanding of how to protect and safeguard the rights of Resident A but noted that you said most communications between yourself, Resident A and his next of Kin took place verbally and were not formally recorded. This is a key requirement in relation to legal protection and to ensure the rights of your residents are understood and protected. The panel was consequently of the view that the lack of formal documents to support any of the agreements made with Resident A or his next of Kin, is inadequate. You did not dispute that there was no advocacy service available to Resident A and stated that his next of Kin advocated for him. The panel found this to be insufficient.

Therefore, the panel found that this charge is found proved.

Charge 1.13)

> “That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.13) Staffing”

The panel at the outset noted that you denied this charge. The panel was of the view that there is sufficient evidence to show that the staffing within your property was not adequate at the time of the visit from London Borough of Greenwich on 6 May 2022. The panel noted that you did not have your own staff, and although it acknowledged the difficulty in obtaining staff due to the Covid-19 Pandemic, it was concerned that you appeared to have failed to accept any responsibility for all staffing matters and passed all of this responsibility to the staffing agency.

The panel noted further that you did not have a rota for your agency staff, having contradicted yourself in that, in your response you had mentioned you were happy with the service the agency provided, but on the other hand, told Person A, that the agency staff were sometimes inconsistent and did not attend work.

Therefore, the panel found that this charge is found proved.

Charge 1.14)

> "That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.14) Record Keeping"

The panel noted your partial admissions of this charge. The panel considered the evidence of Person A, who had stated that the concern relating to this charge was that there were no sufficient or adequate records kept, or no record of any staff meetings having been held. The panel noted that you denied this charge and submitted that you did have regular meetings with your staff members, but these were simply not recorded. You further said, you informed the agency of any issues arising as you had an agreement with them to provide staff supervision. The panel was of the view that, having looked at the

report from the CQC, the evidence of Person A, and your own admissions in relation to your inadequate record keeping, there is ample evidence in relation to this charge.

Therefore, the panel found that this charge is found proved.

Charge 1.15)

> “That you a registered nurse, whilst managing a care facility registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury, did not ensure that the Home was adequate in one or more of the following areas:
>
> 1.15) Care Documentation”

The panel determined that this charge is found proved as its reasoning is synonymous with Charge 1.6 and is based on the same facts.

Charge 2.1)

> “Did not ensure that Resident A’s care had been managed adequately in that you;
>
> 2.1) did not ensure that they had access to the community”

This charge is admitted and therefore found proved.

Charge 2.2)

> “did not ensure that they were able to access one or more of the following areas of the facility independently;
>
> 2.2.1) Garden”

The panel noted that you denied this charge. The panel considered that, under cross examination, you had submitted that Resident A could not access the back garden but was able to get fresh air in the front garden. The panel determined that this charge relates to the back garden specifically, and therefore, by your own admission of Resident A's restrictions to access the back garden independently, found sufficient evidence in relation to this charge. The panel determined that Resident A was not able to access the garden independently in any case, as you outlined that he required support from two carers and a *'Sara Steady'* piece of equipment which enabled the carers to move Resident A without him having to walk. Without access to a wheelchair, the doorways being widened, and the provision of ramps, Resident A was in any case unable to act independently in accessing either garden. The panel also noted that without the relevant ramps, Resident A would not have been able to access the back garden, using a Zimmer frame which you stated Resident A was able to mobilise with.

Therefore, the panel found that this charge is found proved.

Charge 2.2.2)

> "did not ensure that they were able to access one or more of the following areas of the facility independently;
>
> 2.2.2) En suite shower room"

This charge is admitted and therefore found proved.

Charge 2.3)

> "Did not have regard to their wishes with regards to the use of CCTV at the Home"

The panel noted that you denied this charge. The panel took into account your acknowledgement that there was no policy in place relating to CCTV, and that you stated you had discussed the use of CCTV in the presence of the next of Kin, of Resident A.

Under cross examination, you submitted that after the use of the CCTV was explained, the next of Kin then explained this to Resident A, whereby he then followed with a nod, and a thumbs up. The panel noted your statement; *'we talked him through the CCTV with the next of kin, he nodded and gave a thumbs up.'* The panel therefore noted that there is insufficient evidence to find this charge proved and preferred your evidence.

On the balance of probabilities, the panel found that this charge is found NOT proved.

Charge 2.4)

> "Did not ensure that complete records were kept in relation to care and support that had been provided to Resident A"

This charge is admitted and therefore found proved.

Charge 2.5)

> "On becoming aware that the Resident was assessed for use of a wheelchair in October 2021, did not chase the outcome of this referral adequately until June 2022."

This charge is admitted and therefore found proved.

Charge 3)

> "On or around 9 March 2021 informed Person A who was from the Royal Borough of Greenwich that the CQC had passed the service as eligible as a Supported Living Service which was inaccurate."

This charge is admitted and therefore found proved.

Charge 4)

> "Your actions at charge 3 were dishonest in that you sought to create the impression that your service was eligible as a supported living service when you knew it was not."

The panel noted your explanation that you genuinely believed that you had registered as an SLS, considering the circumstances surrounding the registration both from your evidence and that of Witness 1. The panel determined that in relation to this charge, you were unaware of your responsibilities as you were naïve and you found yourself out of your depth. The panel considered the chaotic nature of your establishment at the time and the struggles you were facing due to the Covid-19 Pandemic. The panel was of the view that you were not challenged on this charge during your cross examination or during your evidence. The panel noted that Witness 3 had submitted in his evidence, that he had *'made the changes'* to your registration. The panel determined that it preferred your evidence, in which you stated that you thought you had been registered with the CQC as an SLS.

The panel noted that the allegation of your dishonesty was never put to you by the NMC, and at no point up until this hearing was a dishonesty allegation ever suggested. The panel considered carefully whether it could identify any personal gain for you in being dishonest and noted that up until the making of this charge and the hearing before us, you had never been accused of dishonesty. The precise nature of this dishonesty in this charge was never identified, nor was any gain which would have flowed from that dishonesty. The panel investigated the facts set out in the evidence before it and could not identify any dishonest act on your part, notwithstanding that there were grave uncertainties about the circumstances which led to your property being registered as a care home. This charge relates to 9 March 2021 and the panel noted that you had not received the formal CQC certification until 16 March 2021. The panel noted that certificate of registration from the CQC does not directly mention an SLS or care home, and so the panel could understand the way in which this could be misunderstood.

Therefore, the panel found that this charge is found NOT proved.

Charge 5)

> "On 16 June 2021 when asked by person A as to why the service was showing up as a residential care home responded that 'it is definitely to be supported accommodation' which you knew was inaccurate."

The panel noted that the date in question in this charge is 16 June 2021, which is only a short time after the relevant date in Charge 4. The panel noted that you would have received or have had access to the relevant certificate of registration but it has already noted that this document could be misinterpreted. The panel further took note of the fact that you acknowledged that you had not read the document, in any event. The panel considered the email communication, dated 16 June 2021 in which Person A raised the concern. The panel concluded that the reaction from you, towards Person A, would appear to reflect surprise on your part. The panel noted that you stated, '*I'm not sure why this is, it's definitely meant to be supported accommodation'.* You then asked Person A whether or not you should contact the CQC. The panel was therefore satisfied that your response was more likely one of an individual who was not aware of the inaccuracy of the registration.

Consequently, the panel found that this charge is NOT found proved.

Charge 6)

> "Your actions at charge 5 were dishonest in that you maintained that you were registered as supported living services when you knew you were not."

This charge falls as a result of Charge 5 having been found NOT proved.

Charge 7)

> "On 24 August 2022 sent an email to the NMC stating that you had completed another application in July 2021 to the CQC adding 'personal care' as a regulated activity when you had not."

This charge is admitted and therefore found proved.

Charge 8)

> "Your actions at charge 7 were dishonest in that you sought to create the impression that you had submitted another application to the CQC dated 19 July 2021 when you knew that you had not."

The panel, in relation to this charge, took into account a number of statements you had made within your written self-reflection. The panel noted that you had admitted that the application had never been submitted, and that you accepted it to have been your responsibility. You exhibited remorse for your actions. The panel noted that you say you had submitted the application dated 19 July 2021 to your friend, who was very knowledgeable of CQC procedures, but who you say was unable to attend as a witness due to personal issues.

In considering this charge, the panel noted the email exchange between yourself and Person A on 9 December 2021, in which Person A had asked for an update concerning the current situation with your CQC registration. You responded to his email by stating *'I am open to suggestions on what to do in order to change my registration from care home to supported accommodation'*. The panel noted there was no reference in this exchange to you having completed and/or submitted this application to change your registration with the CQC. The panel determined this response was indicative of someone who knew on 9 December 2021 that she had not at that time completed or submitted a further application to the CQC to change her registration. That being the case, your assertion to the NMC on 24 August 2022, that you had completed another application to the CQC to add 'personal care' to your registration, was dishonest. The panel also considered your claim to have

asked your friend to submit the application on to the CQC once she had reviewed it, to be implausible.

Consequently, the panel found that this charge is found proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

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

Mrs Aziz identified the specific, relevant standards where your actions amounted to misconduct. Mrs Aziz submitted that the facts in this case amount to misconduct and directed the panel to your admissions to some of the charges in your reflection.

Mrs Aziz submitted that the NMC is responsible for setting standards of practice of behaviour in the UK, and the role is to ensure professionals are regulated, are fit to practice and that public trust in the profession is maintained. She submitted that your misconduct has fallen beneath the standards expected in the nursing profession.

Mrs Aziz referenced the following cases: *Roylance v GMC [2002], Remedy UK Limited v GMC [2010], Nandi v GMC [2004] EWHC,* and *Grant v NMC [2011] EWHC.*

Mrs Aziz submitted that Dame Janet Smith's test is important to consider in this case, particularly when considering the fundamental tenets of the nursing profession, and when considering the likelihood of you repeating such behaviours in the future.

Mrs Aziz submitted that, as a registered nurse, it is expected that you must protect and support the health of individual patients and clients, whilst also protecting and supporting the health of the wider community. You must act in a way that justifies the trust and confidence that the public will have in you as a nurse, and also uphold and enhance the good reputation of the profession.

Mrs Aziz submitted that the NMC has determined that the facts proved in this case, do amount to serious professional misconduct.

You submitted that you fully understand the gravity of the situation relating to the concerns raised against your practice.

You submitted that you are very remorseful about the matters raised against your practice. You submitted that you could assure the panel, that you have had time to reflect on the care you provided to Resident A and have recognised the shortcomings in the basic care you provided.

You submitted that you have had time to reflect on all aspects of your nursing career and acknowledged that in your current role as a community psychiatric nurse, you understand and appreciate that patient care and safety is your primary responsibility.

You submitted that you could assure the panel that your misconduct will never be repeated, as you have learned from this experience and also, as you do not intend to set up another care facility, neither now nor in the future.

You submitted that you have never had intentions to hurt anyone, and never would, nor would you ever disobey any laws or disobey policy or procedures. You submitted that you fully understand the importance of honesty and integrity, whilst also understanding that the CQC and NMC were established to keep the public safe.

You submitted that the allegation of dishonesty which has been proven, was an error on your side and for this, you are *'truly, deeply sorry'.* You stated that to be honest is a primary goal in your life, and [PRIVATE], you do not lie and never have the intention to do so.

You submitted that you have learned your lesson, [PRIVATE] You submitted however, that you fully appreciate the seriousness of providing inaccurate, misleading or dishonest information to these bodies, such as the CQC.

You acknowledge that the fact you have failed to meet the nursing standards, could seriously undermine public confidence as well as the wider profession, potentially bringing the nursing profession into disrepute.

You submitted that you are sincerely remorseful for the inconvenience caused by your misconduct.

Submissions on impairment

Mrs Aziz moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mrs Aziz submitted the NMC states that the charge that has been proved in relation to dishonesty, relates to your having deceived staff and colleagues. She submitted that your dishonesty was not a simple breach, but a matter which at its heart, fails to uphold a fundamental tenet of the professional practice, which is honesty and integrity. She further submitted that your conduct as alleged, constitutes the breach of the *NMC Code of Conduct.*

Mrs Aziz submitted that the NMC says that you have demonstrated a lack of appreciation of the seriousness of the allegations and have not shown sufficient insight into the matter. The NMC says that even though you have presented a reflective piece, the quality and the nature of the insight in this reflective piece does not specifically address the concerns as only a few charges were admitted. Mrs Aziz submitted that you have provided developing insight, and not sufficient insight to address the concerns raised.

Mrs Aziz submitted that the public's trust and confidence in a nurse is important, and that you have failed to uphold this trust. She submitted that there has been a risk to the public alongside damage to the integrity of the profession as a result of your misconduct.

Mrs Aziz submitted that therefore, your fitness to practice is currently impaired on the grounds of both public protection and in the wider public interest.

You submitted that you have learned a great lesson from this experience, and are glad you have been open, transparent, and engaged with the NMC fully during all of these processes.

You submitted that you appreciate the importance of regulation and compliance, following the correct policies and procedures in place. You submitted that you would continue to be honest and act with integrity, for the sake of all registered nurses. You further stated that you will make sure that your conduct justifies the trust of your patients.

You stated that you will continue to improve your practice in terms of continuous development, by attending training and seminars to continue to enhance your knowledge. You also outlined the steps you have taken to ensure that this behaviour is unlikely to be repeated. You told the panel how you had completed training in professional standards, patient safety and safeguarding. [PRIVATE]

You stated that you have maintained a reflective journal to regularly assess your actions and decisions, ensuring continuous personal and professional development. You submitted that you have a love for nursing and have wanted to work as a nurse since you were a child.

You submitted that you would like the panel to take into consideration all of the positive testimonials which you have received from your employers, your colleagues, your patients and their families.

You submitted that, having spent time reflecting on this situation, you wish to assure the members of the panel that you now fully recognise the limits of your knowledge and experience. You submitted that you will always prioritise protecting patient safety above all else.

[PRIVATE]

You submit that you believe you have the ability to continue to practice safely and kindly towards your patients, having dedicated your entire professional career to the nursing profession.

You submitted that you are sorry for the concerns you have caused and you are committed to caring for your patients.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. However, the panel did appreciate that breaches of the Code do not automatically result in a finding of misconduct.

The panel noted that the following areas of the Code are engaged:

'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, [2018]'

1) Treat people as individuals and uphold their dignity
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

2) Listen to people and respond to their preferences and concerns

2.1) work in partnership with people to make sure you deliver care

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

4) Act in the best interests of people at all times

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

5) Respect people's right to privacy and confidentiality

5.1) respect a person's right to privacy in all aspects of their care

10) Keep clear and accurate records relevant to your practice

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

13) Recognise and work within the limits of your competence

13.5) complete the necessary training before carrying out a new role

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

18.4) take all steps to keep medicines stored securely

19) Be aware of, and reduce as far as possible, any potential for harm associated with your practice

19.1) take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

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

20) Uphold the reputation of your profession at all times
20.1) keep to and uphold the standards and values set out in the Code
20.2) act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

25) Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
25.1) identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

The panel determined that the breaches in your case are wide-ranging in nature and relate to basic nursing skills. In relation to Charge 8, you were found to have been dishonest, which is a serious professional failure and a breach of the fundamental tenets of the nursing profession. The panel noted that based on these findings, it would be unreasonable if misconduct was not found in this case.

Consequently, the panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*

“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”
If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

‘In determining whether a practitioner’s fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.’

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's “test” which reads as follows:

‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel finds that a patient was put at risk of harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession in that you had acted dishonestly and brought the reputation of the profession into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty as serious. However, the panel determined that your dishonesty was at the lower end of the spectrum and occurred when you were under a particular time of stress. It also noted that throughout your experience of running your business, you appeared to be naïve and out of your depth. The panel concluded that having been through this regulatory process had assisted in you fully understanding and learning from your misconduct, including your dishonesty.

The panel, however, was satisfied that the misconduct has been addressed by your remorse, training, and decision to practice solely as a working nurse and no longer running a business. The panel was impressed to hear from your current line manager commenting on your practice since these matters came to light and gave live testimony as to your honesty and integrity. The panel noted that she was fully aware of the details of these proceedings against you. It considered that the risk of repetition is highly unlikely and carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice.

The panel accepted that you have gone through a *'huge learning curve'* in having attempted to set up and run such an establishment that you had. The panel considered that you have provided evidence of significant remorse and provided detailed reflection, expressing a high level of insight. The panel noted that you have provided multiple examples of steps which you have taken in terms of strengthening your practice, particularly noting your completion of a [PRIVATE], and training in relation to Safeguarding and Professional Standards. The panel further considered the positive testimonials in relation to your character and practice, noting that you have been a registered nurse for many years, with an unblemished career. It noted that you are held in high regard and that there had been no repetition of such conduct since.

The panel therefore decided that a finding of impairment on the ground of public protection is not required.

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

The panel found that the misconduct relating to the establishment of your business, although serious, and at the time presenting a risk to Patient A, had in fact been recognised by you, and remediated. You now do not intend to run such a care establishment in the future. However, the nature of your failings and the finding of dishonesty in your case, mean that the panel feel it is necessary in the interests of upholding proper professional standards and public confidence in the profession, to find current impairment on public interest grounds.

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

Sanction

The panel considered this case very carefully and decided to make a suspension order for a period of 3 months, without review. The effect of this order is that your name on the NMC register will show that you are subject to a suspension order to anyone who enquires about your registration.

Submissions on sanction

Mrs Aziz informed the panel that in the Notice of Hearing, dated 13 May 2024, the NMC had advised you that it would seek the imposition of a striking-off order if it found your fitness to practise currently impaired.

Mrs Aziz submitted that many of the legal principles that were outlined in the submissions made on behalf of the NMC at the impairment stage are also applicable when considering sanctions. She submitted that honesty is of central importance to a nurse, midwife or nursing associate in practice, and therefore, allegations of dishonesty will always be serious. She submitted that, deliberately breaching the professional duty of candour by ‘covering up’ matters which may have gone wrong, could cause harm to people receiving care. Further, she submitted that this dishonesty could cause the misuse of power, harm to vulnerable victims, and direct risk to people receiving care.

Mrs Aziz submitted that the four-stage test in Fuglers LP & Ors v Solicitors Regulation Authority [2014] EWHC, is reproduced in the NMC factors to consider before deciding on which sanction to impose on your practice. She submitted that the NMC guidance requires the panel to have in mind proportionality, aggravating features, mitigating features and previous fitness to practise history.

Mrs Aziz submitted that the aggravating factors which need to be taken into account are in the NMC sanction guidance and they are as follows; *abuse of a position of trust, lack of insight into failings, pattern of dishonesty,* and *conduct which puts patients at risk of*

suffering and harm. She submitted that the NMC guidance on sanction clearly states that putting patients at risk of harm makes a nurse, midwife or nursing associate's failing more serious, and she highlighted that this is an admitted feature which is present in this case.

Mrs Aziz submitted that the NMC say that taking no action in this case would not be appropriate due to the seriousness of the misconduct and the dishonesty that was found, it would not be sufficient to uphold the public interest.

Mrs Aziz further submitted that the NMC say that the imposition of a condition of practice order would be insufficient to protect the public and address the public interest concerns, as there are no conditions which would be workable or measurable.

Mrs Aziz submitted that, as can be seen from the finding of misconduct and impairment on public interest grounds, alongside the finding of dishonesty, a strike-off order would be the appropriate sanction in this case. She submitted that the seriousness of this case requires your removal from the register and that this will be the only sanction sufficient to maintain public confidence in the NMC.

The panel bore in mind that you submitted that you have engaged with the NMC process including the initial interim order which was imposed in 2022. You submitted that the business in question in this case has been closed, and that you do not have any intention of reopening it. You submitted that you want to continue working as a nurse. You submitted that your facility in relation to the charges, was wrongly registered by CQC.

You submitted that the panel should note that as soon as you had realised that the amended application was not submitted to the CQC by your friend, you were very open, honest, and remorseful.

[PRIVATE]

You submitted that you believe that because your business is no longer in existence, and all other concerns which are raised are *'impossible'* to be repeated, you should be allowed

to continue to work as a nurse, and not struck-off the nursing register. You submitted that at this present time, you have apologised and learned from your actions.

You suggested that the sanction of no further action should be implemented at this stage.

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 Sanctions Guidance. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel also took into account the following aggravating feature:

- A breach of the trust which the public place in nurses.

The panel also took into account the following mitigating features:

- Your partial and full admissions to some of the charges;
- You have provided a good amount of insight and evidence of steps you have taken to address the concerns relating to your case, such as; up to date training, you not having taken any further residents after Resident A had left your property and your remorse;
- [PRIVATE]
- [PRIVATE]
- Your acknowledgement of your lack of expertise of the area you attempted to work within;
- You have a good level of experience in relation to clinical nursing, but, notable inexperience as a manager of a care home or manager of a registered premise;

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the fact that you have been found to have been dishonest. 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 interest issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel considered that your misconduct, particularly your dishonesty, was not at the lower end of the spectrum of fitness to practice failures 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;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this

case was not something that can be fully addressed through retraining, as it includes dishonesty.

Consequently, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not uphold the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

You have taken steps to remediate your practice despite no longer running the business and being the registered manager of a care home. In addition to this, the evidence before the panel shows that you have continued to work as a nurse without issue. Although there is an incident of dishonesty and this is considered serious, your dishonesty was not considered to be at the higher end of the spectrum and your actions did not evidence harmful deep-seated attitudinal issues.

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

The panel went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a

suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors, the panel has concluded that a suspension order for a period of 3 months would be the appropriate and proportionate sanction in this case.

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

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

In making this decision, the panel carefully considered the submissions of Mrs Aziz in relation to the sanction that the NMC was seeking in this case. However, the panel considered that a strike-off order would be wholly disproportionate.

In accordance with Article 29 (8A) of the Order the panel may exercise its discretionary power and determine that a review of the substantive order is not necessary.
The panel determined that it made the substantive order having found your fitness to practise currently impaired in the public interest only. The panel was satisfied that the suspension order will satisfy the public interest in this case and will maintain public confidence in the profession as well as the NMC, as the regulator. Further, the substantive order will serve to declare and uphold proper professional standards. Accordingly, the current substantive order will expire, without review.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms McGuinness. She submitted that a suspension order for a period of 18 months would adequately manage the risks identified during the 28-day appeal period, until the beginning of the 3-month suspension order.

Decision and reasons on interim order

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

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

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

That concludes this determination.