Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 10 March 2025 – Friday, 21 March 2025

Virtual Hearing

Name of Registrant:	Graham Joseph Glascott
NMC PIN	93D0084E
Part(s) of the register:	Sub Part 1 RNMH: Mental Health nurse, level 1 (01 April 1996)
Relevant Location:	Manchester
Type of case:	Misconduct
Panel members:	Shaun Donnellan (Chair) Sabrina Sheikh (Lay member) Vanessa Bailey (Registrant member)
Hearings Coordinator:	Fabbiha Ahmed
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter
Mr Glascott:	Present and unrepresented
Facts proved:	Charges 1a,1b,1c,1d,2,3,5a,6a,6b, 7a,7b,7b(i),7b(ii),7c,7d,7e,7e(i),7e(ii),7e(iii),7e(iv), 8a,8b,10,11,12,13,14a,14a(i),14a(ii),14b,15,16
Facts not proved:	Charges 4a,4b,4c 5b(i)5b(ii),9
Fitness to practise:	**Impaired**
Sanction:	**Conditions of Practice Order (3 years)**
Interim order:	**Interim Conditions of Practice Order (18 months)**

Details of charge

That you, a registered nurse, between 1 July 2015 & 31 October 2017, whilst employed the Registered Manager of St Marks Care Centre ("the Home").

1) Having been notified on 4 October 2016 that your management of the Home was failing in the areas listed below, failed to adequately correct matters relating to;

a) Managing staff;

b) Ensuring adequate standards of care;

c) Ensuring availability of the information relating to the Home's performance;

d) Ensuring the implementation of adequate systems.

2) Failed to ensure that one or more residents were given appropriate meals in accordance with recommendations by the Speech & Language Therapy Team, as set out in schedule 1;

3) Failed to ensure that one or more safeguarding incidents had been reported to the CQC and/or Trafford Safeguarding Team, as set out in schedule 2. Between August 2016 and November 2017.

4) Failed to appropriately engage with one or more parties/statutory bodies, namely;

a) Safeguarding;

b) NHS Continuing Health Care;

c) Local authority representatives.

5) Failed to provide adequate care to residents, in that you;

a) Did not ensure that action plans were being followed up in a timely manner.

b) Did not ensure that agency staff had access to the;

i) Computer systems;

ii) Hard copies of care plans.

6) Failed to ensure there were improvements in the service or training requirements for;

a) Monthly incidents/accidents;

b) Restraint measures.

7) Failed to ensure that staff;

a) Were unable to provide evidence of induction training for one or more staff members.

b) Were working with the required level of competence to complete their role, in that you;

i) Did not ensure that in-house safeguarding training had been followed up for one or more staff members;

ii) Did not ensure that one or more staff members had attended local authority safeguarding training.

c) Were supervised appropriately.

d) Were appraised appropriately.

e) Training matrices accurately reflected the training staff had received, in that;

i) Moving & Handling training for 20 staff members had lapsed;

ii) 9 staff members had not completed Moving & Handling training;

iii) Training matrix document indicated that 100% of staff had completed end of life training, but the workbooks had not been completed;

iv) Workbooks/Falls prevention training had not been completed by any staff member on Worthington Suite.

8) Failed to comply with the Deprivation of Liberty Safeguards (DoLS), in that you;

a) Did not ensure that least restrictive interventions were followed to support one or more residents.

b) Did not ensure that's DoLs applications on one or more occasions were made in a timely manner.

9) Did not ensure that residents were granted an appropriate choice of food at mealtimes.

10) Did not ensure that referrals were made in a timely manner when one or more residents had suffered significant weight loss.

11) Did not ensure that there was an effective system in place to manage complaints.

12) Did not ensure that care plans for one or more residents included consultation and/or contributions from family members.

13) On one or more occasions failed to monitor and/or ensure that agency staff followed care plans.

14) Failed to ensure that initial assessments were carried out for one or more residents in an adequate manner, in that you;

a) Did not ensure that the assessments were carried out;

i) In a holistic manner;

ii) With input from the multi-disciplinary team;

b) Did not ensure that assessments from referring bodies were included in care plans.

15) Did not ensure that staff demonstrated an appropriate level of engagement whilst providing one to one support for residents.

16) On one or more occasions did not monitor and/or ensure that risk assessments were completed accurately.

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

Background

The charges arose whilst you were employed as a registered manager by St Marks' Care Centre.

The referral in this matter was made by the Care Quality Commission (CQC). The CQC first became concerned with St Marks following an inspection in August 2016. Following failings identified around safeguarding, St Marks was placed in special measures.

The CQC inspected St Marks again in February 2017 and found that some improvements had been found but there remained four breaches of the Health and Social Care Act 2008.

The CQC undertook further inspections of St Marks on 4, 9 and 11 October 2017. The CQC found that the service users had been exposed to significant harm and that the registrant had not engaged with other agencies by completing safeguarding referrals. On occasion when safeguarding referrals had been made, the content of the referrals was inaccurate with regard to the event being referred.

At the time of the inspection you were, according to the CQC inspector, still in post as Manager, and that you did not leave St Mark's employment until 9 October 2017. Following the inspections the CQC decided to take enforcement action against St Marks and a referral concerning you was made to the NMC.

Decision and reasons on facts

At the outset of the hearing, the panel heard from you. You made full admissions to charges numbers:

1a,1b,1c,1d,2,5a,6a,6b,7a,7b,7b(i),7b(ii),7c,7d,7e,7e(i),7e(ii),7e(iii),7e(iv), 8a,8b,10,11,12,13,14a,14a(i),14a(ii),14b,15 and 16**.**

The panel therefore finds these charges proved in their entirety, by way of your admissions.

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

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: Former employee of CQC (Care Quality Commission)
- Witness 2: 'Expert by experience' employed by the CQC

The panel also heard evidence from you under affirmation.

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 the NMC and you.

The panel was aware that much of the evidence relied on by the NMC was hearsay evidence and sometimes second or third hand hearsay evidence. The panel, as it was advised, is entitled to take hearsay evidence into account and rely on it where appropriate. The panel was also aware that before relying on hearsay evidence it should test that evidence for reliability and accuracy to see if there was other evidence that supported it.

In this case the panel was of the view there was little if any evidence to support the hearsay evidence and decided that it preferred your evidence where it is inconsistent with the hearsay evidence.

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

Charge 4a)

"That you, a registered manager:

"4) Failed to appropriately engage with one or more parties/statutory bodies, namely;

a) Safeguarding;"

This charge is found not proved.

In reaching this decision, the panel took into account your oral evidence, the email dated 31 July 2017 between officials at Trafford Council regarding the improvement plan from St Marks' Care Centre.

The panel paid close attention to the documentary evidence, which established that you had a duty to appropriately engage, however it determined that there was insufficient evidence put before it to suggest that you did not appropriately engage with safeguarding statutory bodies. The panel considered the email dated 31 July 2017 from Trafford Council at the Community Social Work Team which said:

"Safeguarding had been delegated to the whole nursing staff."

The panel therefore understood that the safeguarding duties had been delegated to all nursing staff.

The panel had sight of your response to regulatory concerns letter dated 31 January 2018, in which you said you tendered your resignation in August 2016 following the CQC inspection, and that you sent numerous e-mails regarding your concerns and the expectations placed on you during your employment and a suitable candidate was not appointed until July 2017.

Also, in your context form requested by the NMC dated 17 January 2022, you say:

> *"I invited representatives from the local CCG and social services to attend the home I was in charge of. The representatives from these external services visited on a regular basis both announced and unannounced as invited. They came to review the action plans that were developed for the home and to actively participate in regular meetings to review the action plans and inspect the home."*

The panel found that your oral evidence was consistent with the contents of these two documents (the regulatory concerns letter dated 31 January 2018, and your context form dated 17 January 2022).

The panel also took into account that the local authority in the email, dated 31 July 2017, had highlighted the improvement in relation to safeguarding.

> *"Generally, I can genuinely say that things are gradually improving with the way St Marks' staff are dealing with safeguarding issues…"*

The panel acknowledged the concerns regarding the management of the home were formally raised in the letter to the directors of St Marks' Care Centre from the Trafford Clinical Commissioning Group (CCG) on 19 June 2017. However, the panel determined that by this time you had little influence on the management of the home and that you had not seen this letter. It determined that the evidence did not sufficiently establish that you personally failed to engage with safeguarding bodies. It carefully considered the balance of probabilities and found that evidence from Witness 1 and Witness 2 was not sufficiently cogent to be relied on.

Accordingly, the panel finds charge 4a not proved.

Charge 4b)

> "That you, a registered manager :
>
> 4) Failed to appropriately engage with one or more parties/statutory bodies, namely;
>
> b) NHS Continuing Health Care;"

This charge is found not proved.

In reaching this decision, the panel determined that there was insufficient evidence before it. It noted that there was no evidence from NHS Continuing Health Care (CHC) and considered your live oral evidence.

The panel noted that during your live evidence you stated that CHC staff had fob access to the home allowing them to see residents who had CHC funded placements at any time. They also had access to their electronic care plans to establish whether care being delivered addressed the residents identified care needs. It may have been that when they came unannounced that you were busy elsewhere in the home, however you explained that CHC staff could talk to any other nurse in the home if they had any questions.

The panel considered that whilst you remained the registered manager on paper you were not physically present at St Marks' Care Centre and were therefore, unable to engage. You told the panel that there was a new appointed manager who should have had contact with CHC.

The panel determined that it had insufficient/ cogent evidence to suggest that you did not appropriately engage with CHC.

Accordingly, the panel finds charge 4b not proved.

Charge 4c)

"That you, a registered manager :

4) Failed to appropriately engage with one or more parties/statutory bodies, namely;

c) Local authority representatives."

This charge is found not proved.

In reaching this decision, the panel took into account the letter dated 19 June 2017 from the CCG to the directors of the home. In the letter it is alleged that there had been a lack of response from the service manager to engage with the team. You told the panel that you

were not shown the letter nor told of its contents and by this time your ability to manage day to day business of the home had been significantly reduced.

The panel took into account the emails from Trafford Council dated 13 January 2017 and 31 July 2017.

The panel found that the email dated 13 January 2017 from Trafford Council highlighted a visit from the local authority to St Mark's Care Centre. It found that the email outlined existing systems and advice given to you regarding the Care Centre. The email referenced:

> *"Actions: Weekly meeting to make sure that common themes within safeguarding referrals are dealt with appropriately and monitored in a timely manner."*

The panel concluded the two emails did demonstrate there had been some engagement between Trafford Council and you.

The panel heard from you in your live evidence that there were *"weekly visits",* it found that your reference to weekly visits and ongoing actions provides cogent evidence of a sufficient level of engagement with local representatives.

Accordingly, the panel finds charge 4c not proved.

Charge 5b)

"That you, a registered manager:

5) Failed to provide adequate care to residents, in that you;

b) Did not ensure that agency staff had access to the;

i) Computer systems;

ii) Hard copies of care plans."

This sub-charge is found not proved.

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

The panel heard from Witness 2, she stated that:

> *"So there were five units, I'm not saying there was only one computer in the building. There was one computer on that unit that I was on."*

The panel determined that agency staff did have access to computers. It heard from you in your live testimony that,

> *"All agency staff received inductions and were provided with access to the computer."*

The panel were not shown any reliable evidence to demonstrate that agency staff did not have access to the computer systems.

You also told the panel that you were not responsible for providing additional computers, the panel found that you fulfilled your duty to provide access to the agency staff. The panel noted that the evidence regarding the alleged lack of computers originated from hearsay evidence from Witness 2. The panel did not hear from the staff members who directly spoke to Witness 2 at the home.

It found that there was not enough evidence to support that agency staff did not have access to computer systems.

In relation to access to hard copies of care plans the panel heard from you. You told the panel that producing hard copies of the care plans was impractical due to their extensive and complex nature. You stated that:

"Summaries of care plans, covering the key points and handover information were available at the nurses' station."

The panel determined that your evidence was conclusive in that there was no evidence to suggest that these summaries were inadequate or inaccessible to agency staff. It determined that it would be impossible for you to provide hardcopies of care plans because of the complexity of each individual need. The panel noted that full copies of the care plans were available on the computers to which staff had access.

Therefore, charge 5b is not proved.

Charge 9)

"That you, a registered manager:

9) Did not ensure that residents were granted an appropriate choice of food at mealtimes."

This charge is found not proved.

In reaching this decision, the panel took into account the evidence from Witness 1, Witness 2, your live evidence and the CQC report.

The panel heard from you that, the meal options were dictated by St Marks' Care Centre's budget and the operational policies of the home's owners. The panel found that this indicated a systemic issue beyond your direct control. You told the panel that you had raised concerns about the limited meal choices and the quality of the meals on offer, consisting of two hot meals and sandwiches, with management at the time, but no changes were implemented. You believed that this was due to budget constraints, and you further stated

that you understood the other two homes owned by the same company had similar concerns.

Witness 2 told the panel that the home had the ability to prepare alternative meals that were quick to put together if residents disliked the menu options. The panel acknowledges the limitation of sandwich options but recognises that the discrepancy of alternative menu options could potentially be attributed to the budget allocated to the caterers.

The panel found that the evidence presented was second hand hearsay at best, it also found that complaints regarding food quality originated from a small number of residents. The panel determined that you had raised concerns about the food service but there was a budgetary constraint influencing the meal options provided by the catering company.

The panel determined that there was insufficient evidence to suggest that you did not ensure that residents were granted an appropriate choice of food at mealtimes.

Accordingly, the panel finds charge 9 not 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

The panel heard from Mr Brahimi, on behalf of the NMC, and from you.

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

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

Mr Brahimi identified the specific, relevant standards where your actions amounted to misconduct. He referred the panel to the following parts of the Code: 1, 10, 17,19,20,21 and 25. Mr Brahimi submitted that your conduct in the admitted charges fell short of what was proper in the circumstances and therefore amounted to misconduct. Mr Brahimi further added that the charges found proved by way of your admission are acts or omissions that fell short of what would be considered proper standards of a nurse acting as a registered manager of the home.

Mr Brahimi submitted that:

> '*The failure to ensure that residents are given appropriate meals goes directly to their well-being and health. Such an omission or delay would not be proper in the circumstances; to not provide staff with relevant training is a catalyst for future*

problems and these charges reflect exactly that problem. Their ability to work effectively was impacted and failure to address these concerns connotes a serious breach by the Registrant. Safeguarding is fundamental to a resident's safety and to have failed in reporting a number of incidents, most of which related to injury, would be regarded as deplorable by fellow practitioners.'

For those reasons, Mr Brahimi submitted that your conduct as set out in the charges, that you have admitted, amounted to misconduct in that you fell short of what was proper in the circumstances of a registered nurse acting as a registered manager and invited the panel to consider that you carried greater authority and responsibility as compared to a registered nurse or those performing under management.

You submitted to the panel that any concerns raised during these interactions were promptly escalated and reported. You told the panel that you understand that references have been submitted from prior places of employment, including both positive testimonials and a reference from the director of your last employment, where you held the position of Clinical Lead/ Clinical Nurse Manager. You submitted to the panel that the latter reference raises concerns regarding your performance, you told the panel that it identifies areas that you feel you have not performed well in.

Submissions on impairment

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

Mr Brahimi submitted that:

'A real risk of harm is immediately apparent in this case as a result of a number of residents having been injured and there being no safeguarding reports. There is also a risk of harm where residents were not given appropriate meals in line with recommendations that should have been followed. These concerns are further exacerbated by action plans not being followed up in a timely manner which go to the core instructions on how each resident is to be treated. These are just some examples of the varying charges that present a risk of harm towards future residents.

Given the number of residents and incidents, the Panel have clear evidence of there being a risk of repetition. One lapse of judgement could be addressed but this case demonstrates several examples where concerns were not picked up nor escalated by the Registrant.

The NMC submit that the public would be adversely affected once they learn of the proven incidents. There will be a concern in the medical profession as to the correct process being followed when attending to vulnerable residents. Guidelines are there to be followed for a reason and in this instance the public will learn that at least 2 were not followed (SALT and the Deprivation of Liberty Safeguards). The Panel will also appreciate that a number of charges represented a duty that the Registrant had and the "failure" to meet these will be known to the public. The position of the Registrant is fundamental as the public will question their confidence of individuals at the upper end of the management hierarchy. An oversight is undesirable but the NMC submit this goes further than that where there are multiple staff and residents affected by the Registrant's conduct

A well-informed member of public (about this case) would now question the quality of responsibility shown to Residents when they admitted to such homes. As a result of the Registrant's failures and conduct, the NMC submit the medical profession has been challenged and evidently been put into disrepute.'

The panel invited you to make submissions, but you declined to make submissions on your current impairment beyond the evidence that you gave in which you acknowledge that your performance was poor at the time. However, you submitted that you attempted to improve communications with the safeguarding team and concerns raised were forwarded to the relevant managers.

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, *Council for Healthcare Regulatory Excellence v NMC and Grant [2011] EXCH 927 Admin) and Johnson & Maggs v NMC 2013 EWCH 2140 [Admin].*

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.'*

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: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code)) in making its decision.

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

1 Treat people as individuals and uphold their dignity;

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;

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

20 Uphold the reputation of your professionalism at all times;

21 Uphold your position as a registered nurse, midwife or nursing associate;

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

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

The panel considered your conduct in relation to Charges 1a,1b,1c,1d,2,3,6a,6b, 7a,7b,7b(i),7b(ii),7c,7d,7e,7e(i),7e(ii),7e(iii),7e(iv),8a,8b,10,11,12,13,14a,14a(i),14a(ii),14, 15 and 16 fell short of the standard expected of a nurse acting as a registered manager. The panel found that your role as a nurse acting as a registered manager was to ensure that all residents were safe in all aspects of residing at St Marks'. The panel found that ultimately, you had the responsibility and the duty to protect those under your care including your staff and the residents.

In reaching its decision in relation to charge 1 the panel found that you failed to adequately perform your duty as a nurse acting as a registered manager. The panel applied the same rationale to charge 2 in that you failed to ensure residents were given appropriate meals where this concern was raised to you on multiple occasions. The panel specifically noted that in relation to charge 3, the incident occurred on multiple occasions where your duty to make sure that these safeguarding issues were reported. The panel determined that the failures identified in these charges were serious and exposed very vulnerable people to a significant risk of harm.

In relation to charge 5a, you accepted this charge, but the panel were unable to ascertain what was meant by ‘action plans being followed up in a timely manner.’ Therefore, the panel did not find charge 5a to constitute to misconduct.

In relation to charge 6, the panel considered the importance of improvements in the service and training requirements. The panel determined that it is not possible to improve a service if there are no performance management records. In a similar light, the panel had regard to charge 7, it determined that it was your duty to be up to date with training requirements of staff within the home. The panel found that this was serious misconduct in that it was your responsibility as the registered nurse acting as a registered manager to ensure minimum standards of care are established and maintained.

The panel bore in mind that a registered nurse acting as a registered managers are in highly regarded positions and a fundamental part of the role includes the proper management of the home. However, your actions in Charges 10,11,12,13,14,15 and 16 were all acts of omissions of your duty to ensure that there were effective systems in place to manage complaints and contributions from family members.

Initial assessments for one or more residents were inadequately carried out resulting in poorly planned care and inadequate risk assessments resulting in potential harm to residents. The panel took the view that you had a duty to act in the best interest of your staff and the residents under your care, which you failed to do. The panel therefore found that your actions in these charges amount to misconduct.

The panel found that your actions did fall seriously short of the conduct and standards expected of a registered nurse acting as a registered manager 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.'*

Registered nurse acting as a registered manager occupy a position of privilege and trust in society and are expected at all times to be professional. Residents and their families must be able to trust a registered nurse acting as a registered manager with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their residents' 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 residents 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 found that limbs A-C of *Grant* were engaged. The panel found that, limbs A-C of *“the test”* speak directly to charges found proved. You put residents at unwarranted risk of physical harm, you are liable in the future to bring the medical profession into disrepute and had breached one of the fundamental tenets of the medical profession.

The panel finds that residents were put at risk and were caused harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel had sight of references from your current and previous employers. The panel determined that these testimonials did not reassure it that such conduct would not be repeated. The testimonials

did not provide recent information of your conduct as a registered nurse acting as a registered manager.

Regarding insight, the panel noted that you made admissions at the outset of the hearing. However, the reflective piece provided by you did not acknowledge the impact of your conduct towards residents, staff, and the wider nursing profession.

The panel carefully considered the evidence before it in determining whether you have taken steps to strengthen your practice. The panel has no evidence before it of your practising in a similar role and the training you state you have undertaken did not directly address the concerns raised in the proved charges. The panel felt that you had several years to remediate adequately and had not done so.

The panel also heard from you during your live evidence and determined that you have no desire to return to the role of registered manager.

The panel is of the view that there is a risk of repetition based on your limited insight and the lack of evidence of strengthened practice in the role of registered nurse acting as registered manager. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC, to protect, promote and maintain the health, safety, and well-being of the public and residents, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that a finding of impairment on public interest grounds is required.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of three years. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Mr Brahimi informed the panel that the NMC submit that a Suspension Order of up to 12-month would be appropriate in this case.

Mr Brahimi further informed the panel that:

> *'The NMC have sought to assist the Panel by going through each of the possible sanctions and when weighing the evidence against the set guidance, it is justified that there be a suspension order. When assessing the misconduct by the Registrant, it can be argued that this is behaviour is very serious and there needed to have been more evidence by way of training in the areas of concern. This sanction would reflect that the conduct of the Registrant has been properly addressed and maintain trust with the public that the NMC do take such allegations seriously and will take swift and appropriate action.*
>
> *The NMC respect that the Panel is entirely at liberty to proceed as they deem most suitable for this case. If the Panel consider that a Conditions of Practice Order is more appropriate, then the Panel are invited to take time in considering very careful*

and appropriate conditions that would allow future Panels to test the Registrant's compliance. It is noted that the Registrant no longer wishes to work as a registered manager and has expressed a desire to remain in roles such as a general nurse with his current agency at Search.'

At the sanction stage you gave verbal submissions about your desire to continue working as a registered nurse and were prepared to be monitored in any way in the workplace if a conditions of practice order was imposed.

You explained that suspension would mean you were unable to earn a living and would force you to leave nursing to seek alternative employment. You said you loved your job as a mental health nurse and got great satisfaction from being able to help people cope with their illness.

You made it quite clear that your time as a registered manager had not suited your skill set and you had no intention or desire to return to a managerial role.

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 aggravating features:

- Vulnerable patients were put at risk of harm
- Multiple failings over a period of time

- You showed limited insight into the impact your failings had towards residents, colleagues and wider nursing profession

The panel also took into account the following mitigating features:

- Early admissions to majority of the Charges (the contested Charges were all found not proved)
- Length of time that had lapsed since the incident

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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether 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 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.

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

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response.

This was a very finely balanced decision, with several competing considerations. The proved charges were serious and could have caused harm, but you have practised without restriction for over 7 years since the incidents and during this time you have not had a disciplinary finding. Your reflection was limited but during your oral evidence and in your submissions, you clearly accepted the blame for your failings, and indeed in your verbal submissions at the sanction stage you had started to understand the wider impact of your actions.

You have stated that you have no desire to return to the role of registered manager, or indeed in any managerial role and want to remain as a nurse, or possibly clinical lead at a time when the NHS has a need for experienced nurses.

The panel carefully considered the Sanction suggestion made by Mr Brahimi, but in working through the available sanctions they found that they could protect the public and also act in the public interest by imposing a conditions of practice order that contained conditions that were relevant, proportionate, workable and measurable would be sufficient to protect the public and act otherwise in the public interest by maintaining standards and confidence in the profession and the NMC as a regulator.

The panel determined 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 keep us informed about anywhere you are working by:
>   a) Telling your case officer within seven days of accepting or leaving any employment.
>   b) Giving your case officer your employer’s contact details.
>
> 2. You must keep us informed about anywhere you are studying by:
>   a) Telling your case officer within seven days of accepting any course of study.
>   b) Giving your case officer the name and contact details of the organisation offering that course of study.
>
> 3. 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.

e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

4. You must tell your 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.

5. You must allow your 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

6. You must not work as a registered manager/deputy manager/ assistant manager

7. You need to continue to develop your insight of your failings through a reflective piece

8. A written report to be provided from a supervisor outlining your performance in the role:
    a. How you oversee the challenge of supervising staff
    b. How you have escalated concerns appropriately

9. You must continue to strengthen your practice through leadership training and training in the application of

safeguarding and mental capacity to nursing practice in a supervisory role

The period of this order is for three years.

Before the order expires, 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:

- Evidence of professional development, including documentary evidence of completion of the above reflective pieces and testimonials from a line manager or supervisor that detail your current work practices.

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover the period during which an appeal might take place.

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

That concludes this determination.