Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 12 February – Monday, 4 March 2024
Monday, 28 October – Monday, 4 November 2024
Monday 3 March 2025 – Wednesday 5 March 2025

Virtual Hearing

Name of Registrant:	**Jasbinder Richards**
NMC PIN	06G0252E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA: Adult nurse, level 1 (July 2007)
Relevant Location:	Birmingham
Type of case:	Misconduct
Panel members:	Rachel Onikosi (Chair, lay member) Pauline Esson (Registrant member) David Boyd (Lay member)
Legal Assessor:	William Hoskins (Monday, 12 February – Friday, 16 February 2024) (Tuesday, 27 February – Monday, 4 March 2024) (Thursday, 24 October – Monday, 4 November 2024) Michael Epstein (Monday, 19 – Monday, 26 February 2024) Paul Hester (Monday 3 March 2025- Wednesday 5 March 2025)
Hearings Coordinator:	Franchessca Nyame (Monday, 12 February– Monday, 4 March 2024 and Monday, 28 October – Monday 4 November 2024) Sophie Cubillo-Barsi (Monday, 3 March 2025 – Wednesday, 05 March 2025)

Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Mrs Richards:	Present and represented by Timothy Akers, instructed by the Royal College of Nursing (RCN)
No case to answer:	Charges 1a)ii), 1b)i), 1b)iii), 1b)vi), 1b)vii), 1b)viii), 1c)i), 1c)ii), 1c)iii), 1c)iv), 1c)v)
Facts proved:	Charges 1a)i), 1d)i), 1d)ii), 1d)iii), 1d)iv), 1d)v), 1e, 1j)i), 1j)ii), 1j)iii), 1j)iv), 1j)v), 2c)i), 2d)i) 2d)ii), 3a, 3b, 4a)i), 4d)i), 4d)ii)
Facts not proved:	Charges 1b)iv), 1b)v), 1f, 1g)i), 1g)ii),1g)iii), 1h, 1i, 2a, 2b, 2c)ii), 2d)iii), 3c)i), 3c)ii), 3c)iii), 3c)iv), 3c)v), 3c)vi), 4a)ii), 4a)iii) 4a)iv), 4b, 4c, 5, 6, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i, 7j, 7k, 8a, 8b, 8c, 8d, 8e and 9
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order – 18 months. To be reviewed at 12 months**
Interim order:	**Interim conditions of practice order – 18 months**

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kennedy, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of Charges 1, 1d)iii), 2, 2d)i), 4a)iv), 8d, and 9.

The proposed amendments were to correct the typographical errors in the charges. It was submitted by Mr Kennedy that the proposed amendments would allow the charges to read more sensibly and would not change the character of the charges. He also submitted that the proposed amendments could be made without prejudice to you.

"That you, a registered nurse:

1) While employed at the Acorn Care Home, at the time of a~~n~~ documentation audit between March and July 2017:

…

d) Failed to ensure sufficient information was recorded on clinical risk assessments, in that:

…

iii) In relation one or more residents, the risk ~~raking~~ **rating** of low, medium or high was not recorded

2) Failed to adequately investigate complaints raised **by** relatives of the residents of The Green Nursing Home ("The Green") in that you:

…

d) In relation to Resident O:

i) Following a meeting on 5 November 2018, failed to address Resident O's family's concerns regarding the Resident's treatment between September 2018 and November ~~2019~~ **2018**

…

4) Failed to work collaboratively with colleagues in that you:

a) In relation to Colleague B

…

iv) Pressured Colleague B to complete **work** in respect of your new position at Cole Valley Care Home ('Cole Valley') which was outwith her employment at The Green

8) In and around May 2019, you:

…

d) Requested payment be made to you by Cole Valley in respect of the stationary which was the **property** of The Green.

…

9) Your actions in respect of any or all of charges ~~7~~ **8**a), b), c), d) and/or e), above…"

Mr Akers, on your behalf, did not oppose the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. The panel therefore decided it was appropriate to allow the amendments.

Detail of charges as amended

That you, a Registered Nurse:

1) While employed at the Acorn Care Home ('the Home'), at the time of a documentation audit between March and July 2017:
   a) Failed to ensure the following residents' care files accurately recorded the conditions they suffered from:
      i) Resident B's care plan for specialist seating incorrectly identified his diagnosis as Motor Neurone Disease; **[PROVED BY ADMISSION]**
      ii) Resident C's care plan for sleeping incorrectly identified his diagnosis as sleep apnoea; **[NO CASE TO ANSWER]**

   b) Failed to ensure that the following documents were included in one or more residents' care file:
      i) Falls Analysis; **[NO CASE TO ANSWER]**
      ii) Care Plan for unable to use the call bell; **[NOT PROVED]**
      iii) Mobility clinical risk assessment; **[NO CASE TO ANSWER]**
      iv) Mental Capacity clinical risk assessment; **[NOT PROVED]**
      v) Pressure risk clinical risk assessment; **[NOT PROVED]**
      vi) Working and Playing clinical risk assessment; **[NO CASE TO ANSWER]**
      vii) Sexuality clinical risk assessment; **[NO CASE TO ANSWER]**
      viii) Cognitive clinical risk assessment; **[NO CASE TO ANSWER]**

   c) Failed to ensure the information contained residents' care plans was accurate, in that:
      i) Resident D's care plan inaccurately recorded that Dupuytrens Syndrome was as a result of Motor Neurone Disease; **[NO CASE TO ANSWER]**
      ii) Resident B's care file incorrectly stated he had refused a pressure relieving mattress; **[NO CASE TO ANSWER]**
      iii) Resident B's care file recorded his mobility level inconsistently; **[NO CASE TO ANSWER]**

iv) Resident A's observations level requirement was recorded as 1:1 care, when he required 15-minute observations; **[NO CASE TO ANSWER]**

v) Resident G's date of birth was wrong; **[NO CASE TO ANSWER]**

d) Failed to ensure sufficient information was recorded on clinical risk assessments, in that;

i) Resident A's clinical risk assessments do not state what the risk is; **[PROVED BY ADMISSION]**

ii) Resident A and/or Resident G's clinical risk assessments do not provide information on how to manage the risks identified; **[PROVED BY ADMISSION]**

iii) In relation one or more residents, the risk rating of low, medium or high was not recorded; **[PROVED BY ADMISSION]**

iv) In relation to one or more residents, the clinical risk assessments were over a year old; **[PROVED BY ADMISSION]**

v) In relation to one or more residents, the information in clinical risk assessments did not match the care plan; **[PROVED BY ADMISSION]**

e) Failed to ensure the documentation in respect of one or more residents was legible. **[PROVED BY ADMISSION]**

f) Failed to ensure the quality of care reviews in respect of Resident E in that there was no evidence that relevant stakeholders had been invited to attend; **[NOT PROVED]**

g) Failed to ensure that best interests meetings had taken place in respect of:

i) Resident D concerning botox treatment; **[NOT PROVED]**

ii) Resident E concerning personal care; **[NOT PROVED]**

iii) Resident G concerning his door being locked during the day; **[NOT PROVED]**

h) Failed to ensure that Mental Capacity Assessments were carried out in respect of one or more residents; **[NOT PROVED]**

i)Failed to ensure that one or more residents had Hospital Passports available; **[NOT PROVED]**

j)Failed to ensure one or more of the following residents' PRN protocols were legible and/or signed two by nurses:

i) Resident B; **[PROVED BY ADMISSION]**
ii) Resident I; **[PROVED BY ADMISSION]**
iii) Resident K; **[PROVED BY ADMISSION]**
iv) Resident L; **[PROVED BY ADMISSION]**
v) Resident M; **[PROVED BY ADMISSION]**

2) Failed to adequately investigate complaints raised by relatives of the residents of The Green Nursing Home ('The Green') in that you:

a) Failed to investigate a concern raised by Colleague A that her mother's arm was swollen within a reasonable time; **[NOT PROVED]**

b) Failed to investigate and/or address reports of Residents' property being stolen; **[NOT PROVED]**

c) Between September 2018 until May 2019, in relation to Resident N:

i) Failed to address concerns about the provision of dental treatment for Resident N; **[PROVED]**
ii) Failed to address concerns about the lack of arrangements for bathing for Resident N; **[NOT PROVED]**

d) In relation to Resident O:

i) Following a meeting on 5 November 2018, failed to address Resident O's family's concerns regarding the Resident's treatment between September 2018 and November 2018; **[PROVED]**

ii) Failed to address the family's request for Resident O to move to a downstairs room; **[PROVED]**

iii) Failed to address the family's request for a pendant alarm. **[NOT PROVED]**

3) Failed to communicate effectively with the relatives of residents of The Green in that you:
   a) Following the meeting of 5 November 2018, declined a review meeting with the relatives of Resident O; **[PROVED]**

   b) Said to Colleague A words to the effect of "well I'm looking after her, not you"; **[PROVED]**

   c) On or around 6 March 2019, you communicated inappropriately with a relative of Resident N in that you:
      i) Allowed the exchange to occur in a public corridor; **[NOT PROVED]**
      ii) Spoke too loudly; **[NOT PROVED]**
      iii) Spoke in an accusatory and/or aggressive tone; **[NOT PROVED]**
      iv) Belittled the relative; **[NOT PROVED]**
      v) Made no attempt to de-escalate the exchange; **[NOT PROVED]**
      vi) Pushed Resident N's relative. **[NOT PROVED]**

4) Failed to work collaboratively with colleagues in that you:
   a) In relation to Colleague B:
      i) Shouted for Colleague B to pass you a folder which was located right next to you; **[NOT PROVED]**
      ii) Prevented Colleague B from taking her lunch break; **[NOT PROVED]**
      iii) Said to Colleague B "you are paid to do a job, not to think"; **[NOT PROVED]**
      iv) Pressured Colleague B to complete work in respect of your new position at Cole Valley Care Home ('Cole Valley') which was outwith her employment at The Green; **[NOT PROVED]**

   b) Prevented staff from speaking to each other; **[NOT PROVED]**

c) On an unknown date, pushed a table into an unknown colleague's heels; **[NOT PROVED]**

d) Failed to provide adequate handover to Colleague C, the incoming Home Manager of the Green, in that you:
   i) On 30 April 2019 and/or 1 May 2019, cancelled agency workers' shifts resulting in Colleague C having to work those shifts; **[PROVED]**
   ii) Did not adequately explain managerial records, including staff training. **[PROVED]**

5) Failed to ensure staff at The Green were up to date with their manual handling training. **[NOT PROVED]**

6) Between February 2019 and 30 April 2019, failed to accurately assess the acuity and dependency score accurately of one or more residents. **[NOT PROVED]**

7) By the time of your ceasing your employment in The Green on or around 1 May 2019, failed to keep and / or maintain clear and accurate records in respect of:
   a) Sling audits; **[NOT PROVED]**
   b) Mattress audits; **[NOT PROVED]**
   c) COSHH Folder' **[NOT PROVED]**
   d) Health and Safety Audits; **[NOT PROVED]**
   e) The Home's policies and procedures; **[NOT PROVED]**
   f) Quality assurances Files; **[NOT PROVED]**
   g) Complaints files; **[NOT PROVED]**
   h) Serious incidents for 2018-2019; **[NOT PROVED]**
   i) Admission registers; **[NOT PROVED]**
   j) Care notes; **[NOT PROVED]**
   k) Controlled Drugs registers. **[NOT PROVED]**

8) In or around May 2019, you:
   a) Removed from The Green a number of slings which were the property of The Green; **[NOT PROVED]**
   b) Requested payment be made to you by Cole Valley in respect of the slings; **[NOT PROVED]**
   c) Removed stationary which was the property of The Green; **[NOT PROVED]**
   d) Requested payment be made to you by Cole Valley in respect of the stationary which was the property of The Green; **[NOT PROVED]**
   e) received a cheque valued at £1204.37 from Cole Valley part of which represented payment for the slings and/or stationary which were the property of The Green. **[NOT PROVED]**

9) Your actions in respect of any or all of charges 8a), b), c), d) and/or e), above, were dishonest in that you knowingly sought to gain from the removal and/or sale of items which did not belong to you. **[NOT PROVED]**

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

Facts found proved by way of admission

The panel heard from Mr Akers that you made admissions to Charges 1a)i), 1d)i), 1d)ii), 1d)iii), 1d)iv), 1d)v), 1e, 1j)i), 1j)ii), 1j)iii), 1j)iv) and 1j)v).

The panel therefore found the above charges proved by way of your admissions in accordance with Rule 24(5) .

Decision and reasons on application for hearing to be held in private

Mr Kennedy made an application for this case to be held partly in private on the basis that a proper exploration of your case [PRIVATE]. The application was made pursuant to Rule 19.

Mr Akers did not oppose the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be reference [PRIVATE], the panel decided to go into private session as and when such issues are raised.

Background

The NMC received a referral about you on 27 June 2019 from Highbury Nursing Home ('Highbury Home'), Flintvale Limited ('the Provider').

The NMC investigated and identified the following potential regulatory concerns:

1. Poor leadership – in that you failed to:
    a) adequately investigate complaints raised by the residents' relatives
    b) ensure staff were up to date with their training
    c) assess acuity and dependency tools for the residents appropriately

2. Poor communication – in that you failed to communicate effectively with Resident A's family

3. Failed to work cooperatively in that you bullied your staff

4. Failed to keep and/or maintain clear and accurate records

5. Dishonesty – in that you took and sold slings belonging to The Green to Cole Valley when you were not authorised to do so

In 2017, you worked at the Home in the role of Home Manager. The Home was operated by 1st Care Ltd who instructed an independent audit of documentation at the home. Following the review, it appeared that the Home was failing in their responsibility to maintain appropriate records for residents.

You commenced employment at The Green, also owned by the Provider. Your contract became permanent in December 2017.

You left The Green on or around 1 May 2019 and went to work at Cole Valley.

Your role as Care Home Manager included, but was not limited to:

- Day to day operational management of the care home
- Managing and supervising staff
- Managing resources
- Managing staff acuity, resident dependency and staff rotas
- Ensuring staff training
- Maintaining accurate managerial and nursing records
- Ensuring quality assurance by managing complaints
- Auditing, improving and maintaining standards that complied with Care Quality Commission standards

Decision and reasons on application of no case to answer

The panel considered an application from Mr Akers that there is no case to answer in respect of Charges 1a)ii), 1b)i), 1b)iii), 1b)vi), 1b)vii), 1b)viii), 1c)i), 1c)ii), 1c)iii), 1c)iv) and 1c)v). This application was made under Rule 24(7).

Mr Akers made reference to the case of *R v Galbraith* (1981) 1 WLR 1039 which provides:

> '*If there is no evidence that the crime alleged has been committed by the defendant… the judge will ... stop the case…*
>
> *…where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness, or because it is inconsistent with other evidence. Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on the submission being made, to stop the case.*'

Mr Akers also made reference to the case of *R v Shippey* [1988] Crim LR 767, and stated that the panel should assess the evidence as a whole, and if the evidence of Witness 1 is such that it is so self-contradictory that it can be deemed to be tenuous and should suffer accordingly from inherent weakness.

Mr Akers submitted that, in line with Lord Judge CJ's comments in the case of *R v F (S)* [2012] 1 All ER 565, Witness 1 is so unsatisfactory, contradictory, or so demonstrably unreliable that no panel effectively and properly directed could find the misconduct in relation to the charges which rely on their evidence proved.

Charge 1a)ii)

Mr Akers submitted that the panel does not have sight of Resident C's care plan or any other documentary evidence to establish that it is recorded in Resident C's care plan that

they suffered from sleep apnoea. He highlighted that, in Witness 1's oral evidence, they said that they thought the reference to sleep apnoea was in Resident C's notes but "*whereas when* [they] *went to the care plan, there was no mention of sleep apnoea*". Mr Akers further submitted that even if, contrary to the evidence, the panel was to infer a reference to sleep apnoea in Resident C's care plan, the NMC has failed to present sufficient evidence to find that any diagnosis of sleep apnoea was incorrect.

Charge 1b)i)

Mr Akers stated that, in their evidence, Witness 1 asserted that "*if I haven't mentioned it, it means it was in situ*" meaning, if they did not flag up any particular documents as missing in their report, then they accepted that those documents would have been present in the residents' files. He submitted that the only reference to a Falls Analysis being absent is in the Care File Review for the Home under '*Missing Documentation*' and is only in relation to Resident A. Therefore, on the evidence adduced, there were no issues with any other residents' falls analyses being absent. However, when addressing Resident A, Witness 1 conceded that "*part of the Falls Analysis*" was in fact present for Resident A. Mr Akers submitted that, given that part of the Falls Analysis for Resident A is present, the whole Falls Analysis cannot logically be deemed to be missing from Resident A's care file, and thus insufficient evidence has been presented to find the facts proved in relation to this charge.

Charges 1b)iii), 1b)vi) and 1b)vii)

Mr Akers submitted that Witness 1's evidence was so inherently contradictory that it is insufficient to find the facts proven in relation to the above charges. Witness 1 stated during their oral evidence that the Mobility clinical risk assessment, Working and Playing clinical risk assessment and Sexuality clinical risk assessment were all not present in respect of a Resident A, yet they were able to be taken to those very documents in cross examination and they conceded that those documents were not missing as per their

report. Mr Akers submitted that this evidence has been proven to be demonstrably unreliable, and accordingly, the charges have to fall away.

Charge 1b)viii)

Mr Akers submitted that no or insufficient evidence has been adduced to establish that Cognitive clinical risk assessments were missing from Residents' care files, and Witness 1's report positively refers to their inclusion in the Care File Review in respect of Resident G.

Charge 1c)i)

Mr Akers submitted that insufficient evidence has been adduced to establish that Resident D's care plan recorded that [PRIVATE] was as a result of [PRIVATE] because the panel has not been provided with Resident D's care plan, in order for this to be established. Further, in their written statement, Witness 1 accepted that they were not medically qualified. Therefore, it follows that even if the panel was to infer that these words were written in Resident D's care plan without having sight of it, the NMC has been unable to present sufficient evidence to establish that Dupuytrens Syndrome could not be a symptom of motor neurone disease in the absence of expert medical evidence.

Charge 1c)ii)

Mr Akers submitted that insufficient evidence has been adduced to establish this charge as the panel has not been provided with Resident B's care plan in order for this to be established. Moreover, even if the panel was to infer these words were written into Resident B's care file, he submitted that the statement would not be '*incorrect*' because Witness 1 accepted in their oral evidence that Resident B had indeed refused a pressure relieving mattress in the past.

Charge 1c)iii)

Mr Akers reiterated the panel has not been provided with Resident B's care plan to establish that the care file recorded Resident B's mobility inconsistently. He submitted that you did not fail to ensure that the mobility level was recorded accurately because, in Witness 1's oral evidence, they accepted that the mobility level of Resident B was in fact inconsistent and therefore accurately recorded. Witness 1 stated, "*I believe he did have a varied mobility…I think he had a varying ability where different days he could present with different things…some days he needed assistance; some days he could mobilise independently*", and so the panel may take the view that the recording of Resident B's mobility level is, in fact, accurate.

Charge 1c)iv)

Mr Akers stated that, again, the panel has not been provided with Resident A's care plan in order for any inaccuracy to be proven to be established. Furthermore, he highlighted that Resident A's Maintaining a Safe Environment care plan appears to confirm that 15-minute observations were being undertaken, which would suggest that the care plan was accurate. He added that Witness 1 made the following concessions in their oral evidence, when asked by Mr Kennedy, "*Is there anything that makes mention of 1:1 observations?*"

Witness 1: "*I don't think it is in this document. I don't know whether it's in the actual care plan. These are all clinical risk assessments. It all seems to be jumbled up*"

Therefore, Mr Akers submitted that there is insufficient evidence here to establish that Resident A's observation level requirement was recorded as 1:1 in their care plan.

Charge 1c)v)

Mr Akers submitted that insufficient evidence has been adduced to establish that Resident G's date of birth was wrong as all of the dates of birth recorded for Resident G have been redacted bar one. There is therefore no documentary evidence before the panel to establish that there were two different dates of birth for Resident G contained within their care plan, and all the panel has to rely upon in respect of this charge is the purported memory of Witness 1 who repeatedly stated in their report that specific documents were missing when in fact they were not, and who had the temerity to suggest that the NMC had redacted the wrong care file which was subsequently confirmed as not to be the case by Mr Kennedy.

Mr Kennedy submitted that Mr Akers' submission in relation to Charge 1b)i) is ill-founded as his assertion that the Falls Analysis for Resident A is present is not the case as the Falls Analysis he made reference to related to Resident B. Therefore, the Falls Analysis for Resident A is missing from the documentation.

With regard to Mr Akers' submissions in relation to Charge 1c)v), Mr Kennedy further stated that Witness 1 noted in their contemporary review of the documentation that Resident G's date of birth changes from one date to another. He accepted that it is true that this is there is no documentary evidence before the panel to support this. However, he highlighted that the panel does have Witness 1's evidence in that respect, and he said that it cannot be said that Witness 1's evidence was entirely unreliable as it was quite clear they got it right in respect of some of their evidence because there were admissions to some of the sub-charges stemming from their evidence. On that basis, Mr Kennedy submitted that there is a sufficiency of evidence in relation to this charge.

The panel took account of the submissions made and accepted the advice of the legal assessor. The panel also applied the test set out in *Galbraith*.

Accordingly, the panel considered all the evidence that had been presented to it at this stage. The panel was considering whether evidence had been presented, such that it could find the facts proved i.e. whether you had a case to answer.

Charge 1a)ii)

The panel noted that the Witness 1's report found that Resident C was recorded as suffering from sleep apnoea, but that this was nowhere else in their file. The panel had regard to Resident C's sleeping care plan where there is no mention of sleep apnoea.

The panel was of the view that, in absence of any corroborative evidence that Resident C suffered from sleep apnoea, and after taking the view that there were inconsistencies with Witness 1's evidence, which it found to be inherently weak and vague in some areas, the panel determined that the evidence supporting this charge is tenuous.

Taking the NMC's case at its highest, the panel concluded that the evidence is insufficient to establish a case to answer.

Charges 1b)i), 1b)iii), 1b)vi) and 1b)vii)

The panel bore in mind that the charge specifies that you allegedly failed to ensure that the Falls Analysis, Mobility, Working and Playing and Sexual clinical risk assessments were included in one or more residents' care file. The panel was also mindful that, if there was no mention of these file in Witness 1's report, then these files were in situ. Accordingly, it was only in relation to Resident A that these files were reported to be missing. During the cross examination of Witness 1, they were taken to the relevant areas of the documentation where they confirmed that the reported missing files for Resident A were, in fact, before the panel, thus inconsistent with what Witness 1 stated in their report.

Taking the NMC's case at its highest, the panel concluded that there is no evidence to establish a case to answer.

Charge 1b)viii)

In relation to this charge that Cognitive clinical risk assessments were missing from the residents' care files, the panel again noted that this only concerned Resident A. However, the panel saw that the Cognitive clinical risk assessment was in the documentation before it as reported by Witness 1 but poorly written. The charge does not include any allegation that the document itself was poorly written.

Taking the NMC's case at its highest, the panel concluded that there is no evidence to establish a case to answer.

Charge 1c)i)

In their oral evidence, Witness 1 said that the source document (Care Plan – Dupuytrens Syndrome) was not in the documentation before the panel, but they maintained that Dupuytrens Syndrome and Motor Neurone Disease were conflated and mixed up in the files pertaining to Resident D. However, this source document was not before the panel, and the panel previously determined Witness 1's oral evidence to have limited reliability.

Taking the NMC's case at its highest, the panel concluded that there is insufficient evidence to establish a case to answer.

Charge 1c)ii)

In their report, Witness 1 stated that it was recorded that Resident B refused a pressure mattress. However, during their oral evidence, Witness 1 told the panel that there was a pressure mattress when they checked Resident B's room and that the file had not been updated. However, Witness 1 was not able to say whether the record was accurate or not at the time it was made.

Taking the NMC's case at its highest, the panel concluded that there is insufficient evidence to establish a case to answer.

Charge 1c)iii)

Witness 1 reported that, on Resident B's mobility care plan, the front page states that they can mobilise independently but the last entry states they require two staff and a handling belt. However, in their oral evidence, Witness 1 said that Resident B had "*varied mobility*" which the panel determined confirms why the care plan would have said that. Therefore, the care plan is consistent with Witness 1's evidence.

Taking the NMC's case at its highest, the panel concluded that there is insufficient evidence to establish a case to answer.

Charge 1c)iv)

Witness 1 reported that, in Maintaining Safe Environment care plan, it states that Resident A is on 1:1 supervision whilst in the review section it states 15-minute observations. The panel noted, however, that Witness 1 does not state in their report which entry is incorrect. The panel also noted that, in Resident A's evaluation record, it is recorded four times that Resident A remains on '*15-minute checks*'. The panel did not have the Maintaining Safe Environment care plan before it which Witness 1 said shows Resident A requiring 1:1 supervision. Since the panel had already concluded that Witness 1's evidence was at times limited and weak, the panel determined the evidence to be tenuous in relation to this charge.

Taking the NMC's case at its highest, the panel concluded that there is insufficient evidence to establish a case to answer.

Charge 1c)v)

The panel noted that there is only one date of birth recorded in the documentation for Resident G due to redactions in the document. The only evidence before the panel is Witness 1's oral evidence that two different dates were recorded for Resident G, but the panel has already established Witness 1 as having limited reliability in some areas. There is no way in which the panel can confidently determine whether there was a discrepancy between Resident G's dates of birth.

Taking the NMC's case at its highest, the panel concluded that there is insufficient evidence to establish a case to answer.

Decision and reasons on adjournment

Mr Akers made an application to adjourn proceedings on 4 March 2024. He informed the panel that he had encountered some health-related difficulties which would have an impact on his ability to represent you in this case. Given that the case was going to be adjourned in any event, he requested that the panel adjourn the case at this stage.

Mr Kennedy did not oppose the application.

Having regard to the overall interests of justice and fairness to all parties, the panel decided to adjourn proceedings.

The panel went on to consider the necessity of imposing an interim order under Rule 32.

Mr Kennedy made no application for an interim order.

Mr Akers submitted that an interim order would not be appropriate at this stage.

The panel heard and accepted the advice of the legal assessor.

The panel bore in mind that the only facts found proved at this stage are those found proved by way of your admissions. The panel was aware that there has been no interim order in this case. The panel was of the view that these admissions are such that any risk you may pose to public safety is very low. The panel also noted that you are not currently practising and do not intend to return to practice until this case has concluded.

The panel considered the public interest and determined that public confidence in the profession and the NMC as a regulator would not be undermined if it did not impose an interim order today.

The panel therefore concluded that it was not necessary to impose an interim order on public protection or public interest grounds.

This will be confirmed to you in writing.

That concludes this determination.

Decision and reasons on postponement

In an email dated 24 October 2024 from to the NMC, the RCN made an application for an adjournment until 28 October 2024. The email stated:

> '*We request an adjournment of two days until 28 October, under Rule 23 of the 2004 Rules.*
>
> *We were notified by Counsel's clerk on Tuesday afternoon on 22 October of the situation . We notified the NMC Case Coordinator and lawyer within the hour of the unfortunate and unforeseen situation. The NMC confirmed to the RCN on Wednesday, 23 October that it will not oppose the application.*
>
> *Mr Akers had recent eye surgery. He had expected to have recovered by now. He was told by his doctor that he needs another week to recover and has requested the start date to be pushed back until 28 October.*
>
> *The hearing is part way through the facts stage. It would be manifestly unfair to the registrant nor in the interests of justice to secure new counsel for two days. Temporary counsel for two days would not be able to represent the Registrant as effectively as Mr Akers, given his knowledge of the case and the stage reached. The costs would not be proportionate as new counsel would have had to read into a case that Mr Akers already has valuable intricate knowledge of. It would also be unfair to the Registrant to appear for two days of a substantive hearing at a critical juncture without representation.*
>
> *Mr Akers has criminal trial starting 5 November, so could not accommodate the hearing immediately after the listing. But his availability will be provided today if required*. [sic]'

The RCN attached an Attendance Note to the email which reiterated the information detailed above.

Mr Kennedy submitted that, on the afternoon of 22 October 2024, the NMC was informed that there was going to be an issue with the attendance of Mr Akers and the reason. He informed the panel that the NMC asked the RCN whether or not it would be possible for new counsel to step in. However, the NMC felt that the RCN was making a good point in that this is a complex case.

Mr Kennedy submitted that the NMC's position is that it would not be fair or appropriate for new counsel to step in on short notice at this stage. Therefore, the NMC formed the view that it would be appropriate for this case to be adjourned until 28 October 2024 and indicated to the RCN that there would be no opposition to their application.

The panel accepted the advice of the legal assessor who corrected a mistake in the RCN's written submission and instead directed the panel to Rule 32 (4) of the Rules.

The panel considered the submissions. Given the circumstances and in fairness to Mrs Richards, the panel determined that it would be appropriate to adjourn.

The panel therefore accepted the application.

Decision and reasons on facts

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 from Mr Kennedy and Mr Akers.

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: Independent Consultant for 1st Care Ltd at the time of the incidents
- Witness 2: Deputy Manager of Highbury Home at the time of the incidents
- Witness 3: Manager of Highbury Home at the time of the incidents
- Witness 4: Home Manager of The Green at the time of the incidents
- Witness 5: Daughter of Resident O
- Witness 6: Home Administrator at The Green at the time of the incidents

- Witness 7: Nominated Individual at Cole Valley at the time of the incidents

- Witness 8: Daughter of Resident N

The panel also heard live evidence from you and the following witnesses called on your behalf:

- Witness 9: Nurse at The Green at the time of the incidents

- Witness 10: Nominated Individual at The Green at the time of the incidents and Compliance and Complaints Consultant at Cole Valley

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

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

Charge 1b

> "That you, a registered nurse, while employed at the Home at the time of a documentation audit between March and July 2017, failed to ensure that the following documents were included in one or more residents' care file:
>
> ii) Care Plan for unable to use the call bell;
> iv) Mental Capacity clinical risk assessment;

v) Pressure risk clinical risk assessment; Pressure risk clinical risk assessment."

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into account Witness 1's NMC witness statement, their oral evidence, their Care File Review (CFR) for the Home dated 15 July 2017, and a memorandum dated 21 June 2017 sent from you to the nurses at the Home.

It also had regard to your oral evidence.

In the CFR, Witness 1 stated that the following documents were missing:

- Resident A's care plan for unable to use call bell,
- Resident A's Pressure Risk assessment
- Resident A's Mental Capacity assessment
- Resident F's Mental Capacity assessment

In their NMC witness statement, Witness 1 explained their methodology for the audit. They wrote, '*I only included a random selection of seven residents who were picked based on their room numbers*.' In response to questions from the panel, Witness 1 confirmed that the audit lasted approximately two weeks and they completed part of the audit whilst situated in premises next door to the Home. Witness 1 also told the panel that they could not remember who gave them the files. Witness 1 said they were situated next door and a member of staff brought the files round.

Furthermore, during your oral evidence, you directed the panel to the memorandum you sent to the nurses at the Home which said that you would '*be on annual leave from next*

Monday (26th June) and … back on 17th July.' You further told the panel that you stored various files in your office including Mental Health Capacity files and Deprivation of Liberty Safeguards (DOLS) files which was locked during your annual leave and, in turn, the duration of Witness 1's audit. You said that you had only met Witness 1 briefly and had not seen the report they prepared prior to these proceedings. There had been no discussion between you and Witness 1 as to the contents of their report or the particular concerns they had raised. You emphasised that the Home had been in special measures when you arrived in post and there was no appropriate documentation so that you had to ensure that Mental Health Capacity assessments were completed immediately as they were essential to putting in place DOLS. You said that Pressure Relieving assessments were only applicable to those residents with mobility issues. You said that Mental Health Capacity assessments and DOS files were kept in your office and you think Witness 1 had not seen these and just looked at the care files.

The panel had concerns with regard to how Witness 1 conducted their audit and whether or not Witness 1 even had access to all the files required for a thorough audit. It noted that you had been given no opportunity to address the issues raised and it also took into account your good character and your evidence that this documentation would have been completed as it was essential to the proper care of the residents in the Home.

The panel determined that the evidence provided by the NMC for this charge fell short of satisfying it on the balance of probabilities. As such, the panel found this charge not proved in its entirety.

Charge 1f

> "That you, a registered nurse, while employed at the Home at the time of a documentation audit between March and July 2017, failed to ensure the quality of care reviews in respect of Resident E in that there was no evidence that relevant stakeholders had been invited to attend."

This charge is found NOT proved.

In reaching this decision, the panel considered the same evidence listed under Charge 1b together with Resident E's medical records.

In relation to Resident E's quality of care reviews, Witness 1 reported in the CFR that the '*quality of the review is extremely poor…*'. They noted Resident E's Care Plan in which there was no evidence of Resident E's care reviews or stakeholders being invited to attend Resident E's care review.

However, you provided the panel with '*Weekly Summary*' notes dated 10 - 16 July 2017 which did make reference to stakeholders attending Resident E's care reviews, for example '[PRIVATE] *visited today completed DOLS assessment review*…[PRIVATE] *Advocacy worker visited…*'

For the above reason, the panel determined that the evidence provided by the NMC for this charge fell short of satisfying the panel on the balance of probabilities.

Accordingly, the panel found this charge not proved.

Charge 1g

> "That you, a registered nurse, while employed at the Home at the time of a documentation audit between March and July 2017, failed to ensure that best interests meetings had taken place in respect of:
>
> i) Resident D concerning botox treatment;
> ii) Resident E concerning personal care;
> iii) Resident G concerning his door being locked during the day."

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel had regard to the same evidence listed under Charge 1b.

In the CFR, Witness 1 wrote:

> '*There was no evidence in any files that best interest meetings had taken place, where it was clear a person was being deprived of their liberties…in the file of Resident G, it states* [their] *bedroom, door is locked during the day time…yet there is no evidence that this has been discussed at a best interest meeting. In the file of Resident D, the treatment of Botox for* [their] *Dupuytrene*[sic] *Syndrome does not appear to have gone ahead because the family did not want this. However, this is not supported with a best interest meeting. Resident E appears resistant to personal care, yet there is no best interest* [sic] *to discuss the best way to manage this.*'

You directed the panel to Weekly Summary notes dated 13 July 2017 and 14 July 2017 in which the panel noted reference to best interest meetings for Residents G and E.

In your oral evidence, you told the panel that you met with Resident D's relative, and that Residents D and G were subject to DOLS. The panel bore in mind that there would need to have been best interest meeting in order for the residents to be subject to DOLS.

For the above reason, the panel determined that the evidence provided by the NMC for this charge fell short of satisfying the panel on the balance of probabilities.

The panel therefore found this charge not proved in its entirety.

Charge 1h

> "That you, a registered nurse, while employed at the Home at the time of a documentation audit between March and July 2017, failed to ensure that Mental Capacity Assessments were carried out in respect of one or more residents."

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's CFR, in particular, your evidence that Mental Capacity assessments were kept in your office and that these did not appear to have been accessed by Witness 1.

For the reasons previously stated at Charge 1b, the panel determined that the evidence provided by the NMC for this charge fell short of satisfying it on the balance of probabilities.

The panel therefore found this charge not proved.

Charge 1i

> "That you, a registered nurse, while employed at the Home at the time of a documentation audit between March and July 2017, failed to ensure that one or more residents had Hospital Passports available."

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's CFR report and your oral evidence.

In their report, Witness 1 stated:

‘*By nature of the residents cared for at* [the Home]*, the transfer of information between the home and hospitals is essential, yet none of these files audited had hospital passports.*’

In your oral evidence, you informed the panel that all the residents had hospital passports which were kept at the front of their care files. The panel reminded itself that you were not directly involved in assisting Witness 1’s audit and that you were on annual leave, therefore, unaware what information Witness 1 was provided with as part of their audit. In cross examination, you were adamant that each resident would have had a hospital passport.

The panel determined that the evidence provided by the NMC for this charge was insufficient to displace your oral evidence and therefore fell short of satisfying it on the balance of probabilities.

The panel therefore found this charge not proved.

Charge 2a

“That you, a registered nurse, failed to adequately investigate complaints raised by relatives of the residents of The Green Nursing Home (‘The Green’) in that you:

a) Failed to investigate a concern raised by Colleague A that her mother’s arm was swollen within a reasonable time.”

This charge is found NOT proved.

In reaching this decision, the panel took into consideration Witness 3/Colleague A's NMC witness statement, your oral evidence and a letter from Witness 10 to Witness 3 dated 28 February 2018.

In Witness 3's statement, they said:

> '*…I noticed my mother's arm was swollen so I approached the Jas and informed her of the concern. When I went back the next day and nothing had been done for my mother Jas's response to me was "well I'm looking after her not you".*
>
> *It was established that my mother had a broken arm…'*

In the letter, Witness 10 outlined the chronology of events in relation to Witness 3's complaint. Following their investigation, Witness 10 concluded that '[s]*taff responded to the evidence and symptoms demonstrated without delay*.'

The panel noted that the complaint was raised on 26 February 2018 and Witness 3's mother was initially scheduled a GP appointment for 28 February 2018 and brought forward to 27 February 2018 based on the concerns. Accordingly, the panel was of the view that you responded to the complaint in a timely manner and took reasonable action by ensuring that Witness 3's mother was seen by a doctor who, in turn, referred her to the hospital.

The panel found this charge not proved.

Charge 2b

> "That you, a registered nurse, failed to adequately investigate complaints raised by relatives of the residents of The Green Nursing Home ('The Green') in that you:

b) Failed to investigate and/or address reports of Residents' property being stolen."

This charge is found NOT proved.

In reaching this decision, the panel had particular regard to Witness 5's NMC witness statement and Witness 6's local statement.

In Witness 5's statement, they said:

> '*In April 2019 two of moms gold rings went missing, my Dad reported it to a staff member, again I do not know the specific staff member due to the amount of agency staff. Dad was informed someone would look into it but nobody came back to him. This was raised verbally, we still do not know what happened to mom's rings.'*

In Witness 6's local statement, they said:

> '*There were a number of thefts in the building, which Jas did not act on (to my knowledge)…I do not believe it was ever recorded anywhere either.'*

In your oral evidence, you told the panel that no reports were made to you about the theft of Witness 5's mother's ring, but you did explain an occasion when a separate theft occurred, describing the actions you took to address it. The panel also heard evidence from Witness 10 who explained in detail the complaints process once reports of theft had been made. They recalled that, in relation to this incident, you had carried out an investigation. Whilst the panel noted the evidence of Witness 6 regarding your failure to investigate allegations of stolen property, it noted that under cross examination they used words to the effect of "*not to my knowledge*" hence they were not certain that you did not investigate the thefts that were reported to you.

The panel determined that the evidence provided by the NMC for this charge fell short of satisfying it on the balance of probabilities.

As such, the panel found this charge not proved.

Charge 2ci

> "That you, a registered nurse, failed to adequately investigate complaints raised by relatives of the residents of The Green in that you:
>
> c) Between September 2018 until May 2019, in relation to Resident N:
>
> i) Failed to address concerns about the provision of dental treatment for Resident N;

This charge is found proved.

In reaching this decision, the panel took into account Witness 8's NMC witness statement, Witness 8's letters to The Green dated 6 March 2019 and 4 July 2019, and a handwritten note in relation to dental treatment for Resident N dated 12 March 2019.

In Witness 8's statement, they explained:

> '*I sent a handwritten letter of complaint to* [The Green] *dated 6 March 2019 regarding my mother's urgent need for dental treatment. I received no response to this letter from the Registrant.*
>
> *In July 2019 I became aware that* [The Green] *was under new management. I wrote a letter dated 4 July 2019 attaching my letter dated 6 March 2019 and a complaint I had made to the* [Care Quality Commission (CQC)] *by email*.'

In their letter dated 6 March 2019, Witness 8 wrote in relation to Resident N:

> '…*Since September 2018…I have raised my concern about* [Resident N's *teeth with the manager of* [The Green]…*Some of* [Resident N's] *own teeth had come loose and were missing…*
>
> *I had to cancel an appointment that I made for* [Resident N] *in September as the manager of The Green would not let me take* [them] *to the dentist. Instead, she told me that a visiting dentist will see* [them] *the following week…*
>
> *…The Green's manager herself has promised me on about a dozen occasions that the visiting dentist will see* [Resident N] *'next week' at the same time as saying 'it's not that easy to get a dentist to visit.'* [Resident N] *still does not have any dentures and* [their] *teeth continue to fall out…*'

In your oral evidence, you told the panel that the above was not the case as Witness 8 had not approached you with their complaint until February 2019.

You drew the panel's attention to the handwritten note where it could see that appointments had been made for Resident N in March 2019.

However, the panel considered Witness 8's evidence. Given that Witness 8 wrote the initial letter of complaint to The Green in March 2019 after exhausting their own enquiries for Resident N's dental treatment, a follow-up letter dated 4 July 2019 and an email to the CQC, the panel determined that Witness 8's actions were motivated by their extreme concern about Resident N's deteriorating dental condition and that, as the Home Manager, you failed to address their concerns. The panel also considered Witness 8's evidence in relation to this to be consistent and clear.

For the above reasons, the panel found this charge proved.

Charge 2cii

"That you, a registered nurse, failed to adequately investigate complaints raised by relatives of the residents of The Green in that you:

c) Between September 2018 until May 2019, in relation to Resident N:

ii) Failed to address concerns about the lack of arrangements for bathing for Resident N."

This charge is found NOT proved.

In reaching this decision, the panel considered Witness 8's statement.

In their statement, Witness 8 said:

'*I had never known* [Resident N] *to take a shower. Each staff member who I spoke to assure me that they had shown* [them] *where the bath was and* [they] *did not want to ever use it…After continually raising my concerns for 4 months, I asked to see where the bath was. I was being used like a rubbish skip and had many empty boxes in it. The staff member stated that it had not worked for months…When I took my concerns to the manager again, she stated that there is no point showing the bath to* [Resident N] *as* [they] *could fall…* [sic]*'*

The panel heard evidence from you about the difficulties faced by you and staff when attempting to support Resident N with personal care. You said that every resident had access to bath and shower facilities. You told the panel that, whilst you were not approached by Witness 8 about the lack of bathing provisions for Resident N, you would provide personal care when you realised that this was needed. The panel had sight of Resident N's DOLS application which stated:

'*It is stated that is independent with having a shower and that she enjoys having these where she may spend a lengthy period of time taking a shower…*
She presented as verbally hostile and neglectful in self-care… She is able to look after her own personal hygiene via prompting and assistance from care staff who also help her with her day to day activities.'

In Witness 10's evidence, they informed the panel that there were two available baths on the same floor as Resident N that were readily available.

In absence of further documentary evidence related to Resident N's personal care, and the conflicting oral evidence about the facilities available and the way in which Resident N's personal care was organised, the panel concluded that the NMC had failed to discharge the burden of proof.

On this basis, the panel found this charge not proved.

Charge 2d

"That you, a registered nurse, failed to adequately investigate complaints raised by relatives of the residents of The Green Nursing Home ('The Green') in that you:

d) In relation to Resident O:
   i) Following a meeting on 5 November 2018, failed to address Resident O's family's concerns regarding the Resident's treatment between September 2018 and November 2018;
   ii) Failed to address the family's request for Resident O to move to a downstairs room;
   iii) Failed to address the family's request for a pendant alarm."

This charge is found proved in relation to 2di and 2dii.

Charge 2diii was found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel had regard to Witness 5's NMC witness statement and to the contemporaneous notes of concern they produced.

Witness 5 said in their NMC statement:

> *'…on 05 November 2018, my sister and I had concerns so we arranged a meeting with Jas…*
>
> *I was also very concerned that* [Resident O] *did not have a pendant alarm…*
>
> *I also kept asking for* [Resident O] *to be moved to the ground floor as* [they were] *very isolated and the second floor was not manned all of the time…*
>
> *About 6 weeks later I requested a review meeting as* [Resident O] *still had not got* [their] *pendant alarm and was still not moved downstairs. Jas's response was that she did not think it was necessary*.'

The panel noted that at the meeting on 5 November 2018, a variety of concerns were raised which included the administering of medication via a spoon, the portion size of food, the need for an additional chair in Resident O's room and staff not taking sufficient time to ascertain Resident O's needs. Witness 5 said that you had undertaken to prepare a summary of the meeting and that you would share this with the family, but there was no evidence that this was ever done. The panel determined that, because Resident O's relatives raised concerns with you, you had a professional obligation as manager of The Green to communicate with the relatives regarding the progression in addressing their concerns.

In relation to Charge 2dii, whilst the panel noted the reasons for you not moving Resident N downstairs, which was primarily about funding, you failed to inform Resident O's family about this.

In respect of Charge 2diii, you informed the panel during your oral evidence that you had ongoing discussion with Resident O's relatives about the pendant alarm prior to the meeting on 5 November 2018, and that you had eventually sourced one. The panel determined that you did take steps to address Witness 5's concerns regarding Witness 5's request for a pendant alarm as a result of the ongoing discussions.

In light of the above, the panel found Charges 2di and 2dii proved, and Charge 2diii not proved.

Charge 3a

> "That you, a registered nurse, failed to communicate effectively with the relatives of residents of The Green in that you:
>
> a) Following the meeting of 5 November 2018, declined a review meeting with the relatives of Resident O."

This charge is found proved.

In reaching this decision, the panel considered Witness 5's NMC witness statement and your oral evidence.

The panel had regard to Witness 5's statement which said:

'*About 6 weeks later I requested a review meeting as* [Resident O] *still had not got* [their] *pendant alarm and was still not moved downstairs. Jas's response was that she did not think it was necessary*.'

The panel also considered your oral evidence in which you agreed you declined a review meeting because you felt the issue had been resolved.

The panel therefore found this charge proved.

Charge 3b

"That you, a registered nurse, failed to communicate effectively with the relatives of residents of The Green in that you:

b) Said to Colleague A words to the effect of "well I'm looking after her, not you."

This charge is found proved.

In reaching this decision, the panel took into account Witness 3/Colleague A's NMC witness statement and oral evidence, and your oral evidence.

In Witness 3's statement, they said:

'…I noticed [Resident O's] *arm was swollen so I approached the Jas and informed her of the concern. When I went back the next day and nothing had been done for* [Resident O] *Jas's response to me was "well I'm looking after her not you"'*

Witness 3 reiterated the above in their oral evidence, saying that they thought your comment was "*fair enough"*. In your oral evidence, you told the panel that a conversation

occurred over the phone and, whilst you may have used words to that effect, it was not in those exact words.

The panel determined that Witness 3 had no reason to fabricate this statement, and that they had effectively agreed with the gist of the statement. Nonetheless, the panel considered that the message was conveyed in an insensitive way which amounted to a failure to communicate effectively.

In light of this, the panel found this charge proved.

Charge 3c

> "That you, a registered nurse, failed to communicate effectively with the relatives of residents of The Green in that you:
>
> c) On or around 6 March 2019, you communicated inappropriately with a relative of Resident N in that you:
>
> i) Allowed the exchange to occur in a public corridor;
> ii) Spoke too loudly;
> iii) Spoke in an accusatory and/or aggressive tone;
> iv) Belittled the relative;
> v) Made no attempt to de-escalate the exchange;
> vi) Pushed Resident N's relative."

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel had regard to Witnesses 2 and 8's NMC witness statements, Witness 10's oral evidence, and your oral evidence.

Both witnesses recount a heated interaction between you and Witness 8. Witness 2, in their supplementary NMC witness statement, said:

> '*Jas was very confrontational and was yelling and escalating the situation. The correct procedure would be to de-escalate the situation and discuss the matter privately, but Jas was making it worse*.'

In your oral evidence, both you and Witness 10 denied that you shouted and got physical with Witness 8.

The panel was of the view that an unpleasant exchange occurred at The Green when you prevented Witness 8 from taking Resident N (who was subject to DOLS) out of the building; you had a duty to prevent this. However, whilst a heated interaction may have happened, the panel was not satisfied on the balance of probabilities that your actions were such that it amounted to inappropriate communication. You were faced with a challenging situation to ensure the safety of Resident N.

Therefore, the panel found this charge not proved in its entirety.

Charge 4a

> "That you, a registered nurse, failed to work collaboratively with colleagues in that you:
>
> a) In relation to Colleague B:
>
> i) Shouted for Colleague B to pass you a folder which was located right next to you;

ii) Prevented Colleague B from taking her lunch break;

iii) Said to Colleague B “you are paid to do a job, not to think”;

iv) Pressured Colleague B to complete work in respect of your new position at Cole Valley which was outwith her employment at The Green.”

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into consideration Witness 4’s NMC witness statement and Witness 6’s local statement.

In their NMC statement, Witness 4 stated:

> ‘*A big concern of mine was how Jas treated* [Witness 6] *was disgraceful. I directly witnessed this, Jas was in the office and I heard her shout for* [Witness 6] *and* [they] *would response and Jas asked* [them] *to pass her a folder that was just next to her.*

Witness 6 said in their local statement:

> ‘*I was told that I was not entitled to a lunch break because I need to be there when she (Jas) needed me, but I could have cigarette breaks when I want…*
>
> *…I was once proactive and did something I was told by Jas ‘you are paid to do a job, not to think’*
>
> *…I was never reimbursed for these memory sticks nor the additional hours I worked from home for Cole Valley. I felt used, under pressure to completed*[sic] *work for The Green and Cole Valley.*’

The panel determined that Witnesses 4 and 6's evidence does not support the charge. The charge is very specific and it alleges that you shouted for Witness 6 to pass a folder. In their contemporaneous statement, Witness 6 made no mention of shouting. In relation to Witness 4's evidence, they said that you shouted for the attention of Witness 6 only.

The panel heard from Witness 6 in oral evidence that they would take their own lunch into work or get lunch off the premises when there was enough cover. There was no evidence to support the fact that you prevented Witness 6 from having their lunch break.

In addition, when asked about Charge 4aiii, Witness 6 stated, '*I don't remember why. Why I actually said that at the time. I would imagine there was without sort of guessing or speculating, that was an incident where I had thought outside the box to get a resolution and it wasn't accepted.*' The panel determined that Witness 6's evidence was too vague to support this charge.

In relation to Charge 4aiv, the panel did not have any evidence before it which indicated that you pressured Witness 6 to complete work for Cole Valley, merely that they '*felt*' pressure. This is not the same as you applying improper pressure.

In light of this, the panel found this charge not proved in its entirety.

Charge 4b

> "That you, a registered nurse, failed to work collaboratively with colleagues in that you:
>
> b) Prevented staff from speaking to each other."

This charge is found NOT proved.

In reaching this decision, the panel considered Witness 4's NMC witness statements and your oral evidence.

In their statement, Witness 4 said, '*the staff were miserable, they were not allowed to talk to each other or have fun.*'

You told the panel during your oral evidence that staff worked in pairs and so it was expected that they would have to talk to each other. The panel heard no evidence of you putting in place any policies or practises that prevented staff from speaking to each other.

Accordingly, the panel considered this evidence and determined that the evidence provided by the NMC for this charge fell short of satisfying it on the balance of probabilities.

As such, the panel found this charge not proved.

Charge 4c

> "That you, a registered nurse, failed to work collaboratively with colleagues in that you:
>
> c) On an unknown date, pushed a table into an unknown colleague's heels."

This charge is found NOT proved.

In reaching this decision, the panel considered the same evidence listed at Charge 4b.

In their statement, Witness 4 said, '*I witnessed Jas push a table into a staff member, the table caught the back of their heels.*' However, in cross examination, Witness 4 could not say whether or not they believed your alleged actions to be deliberate.

The panel recognised that, if this charge was to be found proved it required a finding that you intentionally pushed the table into the heels of the unknown colleague. There was no evidence to suggest that you had intentionally done this.

The panel therefore found this charge not proved.

Charge 4d

"That you, a registered nurse, failed to work collaboratively with colleagues in that you:

d) Failed to provide adequate handover to Colleague C, the incoming Home Manager of the Green, in that you:

i) On 30 April 2019 and/or 1 May 2019, cancelled agency workers' shifts resulting in Colleague C having to work those shifts;
ii) Did not adequately explain managerial records, including staff training."

This charge is found proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into account Witness 4's NMC witness statements and 'Typed Up Induction Notes from April 2019'.

Witness 4 said in their statement:

> '*On 01 May 2019 I was working at* [The Green] *and Jas cancelled the agency nurses, she had done this the previous day on 30 April 2019. I came* into [The Green] *with the intention that Jas would be giving me a handover however she informed me she had cancelled the agency staff and I was needed to work on the floor as a nurse*.'

Witness 4 also said in their supplementary statement:

> '*Jas also made the handover very difficult for me. She did not go through any managerial items with me and merely said "all those folders up there are the ones you need and they're all self-explanatory" when we were in her office on the last day. When I reviewed the files, they were all empty.'*

You directed the panel to 'Typed Up Induction Notes from April 2019', denying that you cancelled the agency shifts because you had given a different member of staff responsibility over the rota. However, the panel noted that you continued to work at The Green for another six weeks to ensure a smooth transition period, and that Witness 4 had a meeting with the relevant agency to discuss how shifts would be booked and to prevent you from cancelling shifts in the future.

In relation to Charge 4dii, you told the panel that a handover was conducted with Witness 4 in their capacity as Deputy Manager but, when they became the Home manager, your attempts for a handover were unsuccessful.

In light of the above, the panel found this charge proved in its entirety.

Charge 5

> "That you a registered nurse, failed to ensure staff at The Green were up to date with their manual handling training."

This charge is found NOT proved.

In reaching this decision, the panel took into consideration the NMC witness statements of Witnesses 4 and 5, and the training certificates for staff at The Green provided by you.

In their supplementary NMC witness statement, Witness 4 stated that '*the staff's* [sic] *manual handling knowledge and technique was very poor.*' Witness 5 reiterated this in their statement:

> '*An Agency worker (I saw permanent staff do this as well) stood at the head of the bed and pulled the bed sheet pulling my mom up the bed, I stopped her and said this was not the correct procedure*…'

The panel referred itself to a number of training certificates relating to moving and handling objects and people which were completed by different members of staff at The Green.

The panel was of the view that, whilst the above may be evidence of bad practice, it had no evidence before it indicating that staff at The Green were not trained. In light of this, it determined that the evidence provided by the NMC for this charge fell short of satisfying the panel on the balance of probabilities.

The panel therefore found this charge not proved.

Charge 6

> "That you, a registered nurse, between February 2019 and 30 April 2019, failed to accurately assess the acuity and dependency score accurately of one or more residents."

This charge is found NOT proved.

In reaching this decision, the panel had regard to the Dependency Assessment Tool sheets, the local statement of Witness 4, and the oral evidence of Witness 10.

In their local statement, Witness 4 stated that '*the dependency factors were incorrect'* but told the panel during their oral evidence that they could also be subjective assessments.

In your oral evidence, you said that the scores could remain the same over time and that, whilst they involve speaking to staff, they could also be subjective. You reminded the panel that you were familiar with the residents' conditions. In witness 10's oral evidence, your account was confirmed.

Although the panel had sight of the Dependency Assessment Tool sheets, it received no evidence to show who the residents were and what their diagnoses were.

For these reasons, the panel determined that the evidence provided by the NMC for this charge fell short of satisfying it on the balance of probabilities.

As such, the panel found this charge not proved.

Charge 7

"That you, a registered nurse, by the time of your ceasing your employment in The Green on or around 1 May 2019, failed to keep and / or maintain clear and accurate records in respect of:

a) Sling audits;
b) Mattress audits;
c) COSHH Folder'
d) Health and Safety Audits;
e) The Home's policies and procedures;
f) Quality assurances Files;
g) Complaints files;
h) Serious incidents for 2018-2019;
i) Admission registers;
j) Care notes;
k) Controlled Drugs registers."

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel had regard to Witness 4's local statement, Witness 3's NMC witness statement, and Witness 10's witness statement.

In their local statement, Witness 4 wrote:

'*On my return on the 13 May 2019 I discovered over a period of time that various files were missing they were as follows:*

1. *Sling audits;*
2. *Mattress audits;*
3. *COSHH Folder'*
4. *Health and Safety Audits;*
5. *The Home's policies and procedures;*
6. *Quality assurances Files;*
7. *Complaints files;*
8. *Serious incidents for 2018-2019;*
9. *Admission registers;*

…'

In Witness 3's NMC statement, they said:

> '*When* [Witness 4] *was the manager I went to help* [them] *when the CQC came to inspect and normally they request things like, complaints logs, care notes,* [controlled drugs] *register etc. however these had gone missing.*'

In your oral evidence, you told the panel that you did not remove any of the items set out in the charge and as far as you were concerned they were present.

Witness 10 said in their statement, although many of the files were missing, some were '*present and correct when* [you] *left the Home to work at Cole Valley Nursing Home*' and others you would not have been able to access because, '*After* [you] *left The Green, the access codes to the front door were changed – thereby negating any possibility of* [you] *having access…*'

The panel were referred to a letter dated 28 May 2019 addressed to Witness 10 enquiring about the missing files. The panel was not presented with any evidence that you received a similar letter or that you knew about the issue.

In light of the above, the panel did not have sight of any evidence indicating that you failed to keep and/or maintain accurate records.

The panel therefore found this charge not proved in its entirety.

Charge 8

"That you, a registered nurse, in or around May 2019, you:

a) Removed from The Green a number of slings which were the property of The Green;

b) Requested payment be made to you by Cole Valley in respect of the slings;

c) Removed stationary which was the property of The Green;

d) Requested payment be made to you by Cole Valley in respect of the stationary which was the property of The Green;

e) Received a cheque valued at £1204.37 from Cole Valley part of which represented payment for the slings and/or stationary which were the property of The Green."

This charge is found NOT proved.

Whilst the panel determined each limb of this charge separately, it considered them together as the sub-charges arise from the same set of facts.

In reaching this decision, the panel took into consideration the NMC witness statements of Witnesses 4 and 7, the local statement of Witness 6, financial statements provided by Witnesses 7 and 10, and your oral evidence.

In your oral evidence, you told the panel that you did order slings and stationary from The Green after being given permission by the directors of The Green, but with the intention that these items would be used at Cole Valley. You also told the panel that you accepted the cheque from Cole Valley made payable to you. The panel was informed that Witness 10 quickly rectified this error by writing a cheque back to The Green for the same amount.

In the panel's view, the evidence available indicated that the slings and stationary ordered by you were always intended for use at Cole Valley but that you had been given permission to purchase them by the directors at The Green and Cole Valley. In these circumstances, the panel was not satisfied that the items which you removed were the property of The Green.

In light of the above, the panel found this charge not proved in its entirety.

Charge 9

> "Your actions in respect of any or all of charges 8a), b), c), d) and/or e), above, were dishonest in that you knowingly sought to gain from the removal and/or sale of items which did not belong to you."

This charge is found NOT proved.

This charge automatically falls away as it is contingent on Charge 8 being found proved.

Further, and in any event, the panel was provided with evidence of a cheque and bank statement which confirmed that there was no gain to you by virtue of the transaction undertaken at Charge 8.

Interim order

The panel considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests.

Submissions on interim order

Mr Kennedy made no application for an interim order.

Mr Akers invited the panel to not impose an interim order given that no application for an interim order was made by the NMC and some of the most serious charges have not been found.

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is not necessary for the protection of the public or otherwise in the public interest. The panel considered that to impose an interim order would be inconsistent with its earlier findings.

This will be confirmed to you in writing.

Resuming Hearing – 3 March 2025

Fitness to practise

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

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

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

Submissions on misconduct

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

Mr Kennedy, on behalf of the NMC, referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and highlighted what, in the NMC's view, were breaches of the Code in your case.

Mr Kennedy reminded the panel that at the time the charges arose, you were an experienced nurse with a speciality in bringing failing care homes back to the requisite standards. Consequently, Mr Kennedy submitted that you would have been acutely aware of the need to ensure that care plans were accurate, that risks were properly identified, that staff adhered to medication protocols and that concerns raised by resident's families, were respectfully addressed. In light of your failure to do so, Mr Kennedy invited the panel to find that your actions fell well below the standards expected of a registered nurse and were sufficiently serious to amount to misconduct.

Mr Akers accepted that a *"level of misconduct"* will be found by the panel today. However, he reminded the panel that the NMC originally determined that the concerns relating to Acorn Care Home required no further action. Mr Akers stated that it is only when further issues were raised, that it was decided that regulatory proceedings should commence and the concerns relating to Acorn Care Home, were then included in the charges. Mr Akers asked the panel to carefully consider each charge individually, when determining whether the high bar for misconduct has been met in the circumstances of your case.

Submissions on impairment

Mr Kennedy next 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.

Mr Kennedy referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). In this regard, Mr Kenedy invited the panel to find that as a result of the charges found proved, residents were placed at an unwarranted risk of harm and that your behaviour breached a fundamental tenet of the nursing profession, bringing the reputation of the profession into disrepute.

Mr Kennedy acknowledged that at the outset of the hearing, you made admissions to a number of the charges. He further acknowledged that you have provided a reflective statement and that during the course of this hearing, you have given evidence to the panel, accepting your oversight with regards to record keeping. However, Mr Kennedy submitted that you have failed to demonstrate sufficient insight into the impact your behaviour had upon your colleagues, patients and their families and the reputation of the nursing profession.

Mr Kennedy referred the panel to the training certificates and testimonials before it. He stated that whilst the concerns found proved are capable of remediation, the testimonials you have provided are historic in that they predate the training you have completed. He therefore submitted that the testimonials are unable to assist the panel as to whether you have been able to apply what you have learned into a nursing setting. Mr Kennedy further submitted that, despite being permitted to do so, you have chosen not to work as a registered nurse, and therefore there is no evidence before the panel to demonstrate that you have strengthened your practice. In light of this, Mr Kennedy invited the panel to find that your fitness to practise is currently impaired on public protection grounds.

Mr Kennedy also invited the panel to find that your fitness to practise is impaired on public interest grounds. He submitted that a member of the public would be shocked that a highly experienced nurse would behave in the manner found proved and would expect the NMC, as a regulator, to take action in order to prevent this behaviour being repeated.

Mr Akers reminded the panel that the charges arose some time ago. He told the panel that, since that time, you have undertaken relevant training. This included complaint handling, effective communication in health and social care and, amongst others, conflict management. Mr Akers told the panel that this training was undertaken on your own volition and tailored to address the charges found proved.

Mr Akers next referred the panel to your reflective statement, which he submitted demonstrates an understanding of the importance of clear and accurate records. He

stated that you are able to articulate how your training in customer service has helped you become more mindful of people's expectations, and the importance of properly explaining why an expectation may not be met. Mr Akers submitted that you have took responsibility for your failings.

With regards to your testimonials, Mr Akers referred the panel to those provided by colleagues, patients and family members in relation to your employment at Cole Valley. He stated that these testimonials demonstrate an overall satisfaction with the way the home was run and is indicative of the good job you were doing as a manager. Mr Akers further stated that the testimonials evidence how your practice had improved after the allegations had been made with regards to your previous employment.

Mr Akers submitted that you cannot be criticised for choosing not to work as a registered nurse whilst these proceedings remain ongoing. He told the panel that you want to treat these regulatory proceedings with the upmost seriousness and have devoted your time to address and deal with the concerns raised.

In conclusion, Mr Akers submitted that a member of the public would not be shocked should a finding of impairment not be made today and invited the panel to find that your fitness to practise is not currently impaired.

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 amounted to a breach of the Code. Specifically:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

…

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

8 Work co-operatively

To achieve this, you must:

…

8.2 maintain effective communication with colleagues

…

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

8.6 share information to identify and reduce risk

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

…

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In considering whether the facts found proved amount to misconduct, the panel noted that misconduct must not be seen as anything other than serious professional misconduct. In relation to whether the acts or omissions are serious, the panel further noted that the level is high in that the conduct would be regarded as deplorable by fellow practitioners. In this regard, the panel went on to consider each charge found proved individually, specifically:

1) **While employed at the Acorn Care Home ('the Home'), at the time of a documentation audit between March and July 2017:**

    a. **Failed to ensure the following residents' care files accurately recorded the conditions they suffered from:**
        i. **Resident B's care plan for specialist seating incorrectly identified his diagnosis as Motor Neurone Disease;**

When considering whether this charge amounts to misconduct, the panel acknowledged that at the time the charge arose, you were employed by the Home as a Home Manager and registered nurse. The panel was of the view that as a registered nurse, you would have, or should have known the importance of ensuring that residents' care files accurately recorded the condition they suffered from. Failure to do so placed the residents at a significant risk of harm, in that they may not have received the care they required. In light of this, the panel was satisfied that your actions at charge 1 a) i) did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 1 d) i) and ii)

d) **Failed to ensure sufficient information was recorded on clinical risk assessments, in that;**
    i) Resident A's clinical risk assessments do not state what the risk is;
    ii) Resident A and/or Resident G's clinical risk assessments do not provide information on how to manage the risks identified;

When determining misconduct in relation to the above charges, the panel was of the view that it was your responsibility, as a Home Manager and registered nurse, to share information accurately, to manage and reduce risk by ensuring that other care providers were aware of residents' needs. Failing to do so, placed residents at a significant risk of harm. In light of this failure, the panel determined that your actions at charges 1 d) i) and

ii) did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 1 d) iii) and iv)

d) Failed to ensure sufficient information was recorded on clinical risk assessments, in that;

iii) In relation one or more residents, the risk rating of low, medium or high was not recorded;

iv) In relation to one or more residents, the clinical risk assessments were over a year old;

When considering whether these charges amount to misconduct, the panel was of the view that as a registered nurse, you should have, or would have known the importance of accurate and up to date risk assessments. Failing to do so would have prevented accurate control measures being implemented and potentially, the priority of care for that Resident being mismanaged, placing patients at a risk of harm. In light of your failure, the panel was satisfied that your actions at charges 1 d) iii) and iv) did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 1 d) v)

d) Failed to ensure sufficient information was recorded on clinical risk assessments, in that;

v) In relation to one or more residents, the information in clinical risk assessments did not match the care plan;

When determining misconduct in relation to this charge, the panel was satisfied that failing to ensure that the information contained within a clinical risk assessment matched a resident's care plan, placed patients at a risk of harm. Specifically, there is a requirement for accuracy and consistency in order for appropriate care to be provided to a resident. In

light of your failure, the panel determined that your actions at charges 1 d) v) did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 1 e)

e) Failed to ensure the documentation in respect of one or more residents was legible.

When considering whether this charge amounted to misconduct, the panel determined that maintaining legible documentation was a fundamental responsibility of a registered nurse. As a registered nurse, you should have, or would have known that not meeting this responsibility could cause confusion to those caring for the residents and as a consequence, prevent appropriate care being provided to them. In light of your failure, the panel was satisfied that charge 1e) falls seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 1 j i)- v)

j) Failed to ensure one or more of the following residents' PRN protocols were legible and/or signed two by nurses:

i) **Resident B;**
ii) **Resident I;**
iii) **Resident K;**
iv) **Resident L;**
v) **Resident M;**

When determining whether the above charges amount to misconduct, the panel was of the view that it would have been your responsibility as a Home Manager to ensure PRN protocols were legible and signed by two nurses. The panel considered the fact that countersigning was of the upmost importance, in order to protect residents against any

potential drug errors. Failing to uphold your responsibility in this regard placed patients at a serious risk of harm. In light of this, the panel determined that your failings within charges 1 j) i)-v) did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 2 c) i)

2) Failed to adequately investigate complaints raised by relatives of the residents of The Green Nursing Home ('The Green') in that you:

c) Between September 2018 until May 2019, in relation to Resident N:

i) **Failed to address concerns about the provision of dental treatment for Resident N;**

When considering whether this charge amounts to misconduct, the panel had regard to its previous determination in which it held that as the Home Manager, you failed to address the concerns raised regarding Resident N. The panel determined that you should have acted in a timely manner, particularly given Witness 8's persistence in this regard. In light of your failure to do so the panel was satisfied that charge 2 c) i) does fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 2 d) i)

d) In relation to Resident O:

i) Following a meeting on 5 November 2018, failed to address Resident O's family's concerns regarding the Resident's treatment between September 2018 and November 2018;

When determining whether this charge amounts to misconduct, the panel acknowledged that it was your belief that this matter had been resolved. Despite this, the panel considered the fact that the concerns regarding Resident O's treatment related to fundamental aspects of their care, including the administration of medication, feeding

Resident O and the need for additional equipment within their room. The panel was of the view that as a registered nurse, you would have, or should have known the importance of communicating effectively to provide an update on how the concerns were being addressed, your failure to do so caused distress to Resident O and their family, and the risk of inappropriate care to the resident. In light of this, the panel determined that your actions at charge 2 d) i) did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 2 d) ii)

d) In relation to Resident O:
ii) Failed to address the family's request for Resident O to move to a downstairs room;

When considering this charge in relation to misconduct, the panel noted that you were unable to move Resident O to a downstairs room due to budget restrictions. In light of this, the panel was satisfied that there was good reason why this request could not be fulfilled. It was therefore of the view that your actions at this charge would not be considered deplorable by your fellow practitioners and concluded that charge 2 d) ii) did not amount to misconduct.

3) Failed to communicate effectively with the relatives of residents of The Green in that you:
a) Following the meeting of 5 November 2018, declined a review meeting with the relatives of Resident O;

When determining whether this charge amounts to misconduct, the panel considered the fact that as the Home Manager, it would have been your responsibility to meet with, listen to, and respond to the concerns raised by Resident O's family. The panel was satisfied that your failure to work in partnership with the family, as outlined at charge 3 a), did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 3 b)

3) **Failed to communicate effectively with the relatives of residents of The Green in that you:**
   b) **Said to Colleague A words to the effect of "well I'm looking after her, not you";**

When considering this charge in relation to misconduct, the panel took into account the context of the allegation, noting the evidence from Colleague A who stated that they thought your comment was "*fair enough"*. Whilst your words may not have been considered effective communication, the panel determined that your actions as outlined at charge 3 b) did not fall seriously short of the standards expected of a registered nurse due to the circumstances and therefore did not amount to misconduct.

Charge 4 d) i)

   d) **Failed to provide adequate handover to Colleague C, the incoming Home Manager of the Green, in that you:**
      i) **On 30 April 2019 and/or 1 May 2019, cancelled agency workers' shifts resulting in Colleague C having to work those shifts;**

When determining whether this charge amounts to misconduct, the panel considered the fact that as a result of you cancelling the agency workers' shifts, Witness 4 was required to discuss with the agency how to prevent you from cancelling shifts in the future. The panel was of the view that your failure to provide adequate handover resulted in the Home being understaffed, potentially impacting the staffing levels, placing the residents at a risk of harm. In light of this, the panel was satisfied that your behaviour, as found proved at charge 4 d) i), did fall seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 4 d) ii)

d) Failed to provide adequate handover to Colleague C, the incoming Home Manager of the Green, in that you:

ii) Did not adequately explain managerial records, including staff training.

When considering this charge in relation to misconduct, the panel noted that at the relevant time you had considerable experience as a both a Home Manager and registered nurse. Consequently, the panel was of the view that you should have, or would have known the importance of maintaining effective communication with your colleagues in order to preserve the safety of those receiving care in the Home. In light of your failure to do so, the panel determined that your actions at charge 4 d) ii) did fall seriously short of the standards expected of a registered 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. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. To justify that trust, nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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) ….'

The panel determined that residents were placed at an unwarranted risk of harm as a result of your misconduct. It further determined that your misconduct, which occurred whilst you were in a senior position, had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered that the misconduct found proved is easily remediable.

Looking forward, and when considering your insight, the panel had before it your reflective statement in which you provide some remorse for your failings. However, the panel was of the view that much of your reflective statement is focused upon you, rather than the impact your actions had upon your colleagues, patients, their families and the reputation of the nursing profession. Additionally, you continue to outline excuses for some of your behaviour, rather than focusing upon how to prevent a similar situation arising in the future.

The panel was encouraged by the training certificates before it. However, the panel noted that much of the training was completed exclusively online in January 2024, within a short period of time. Given the progression of these proceedings since January 2024, the panel would have been assisted with evidence of more up to date training. The panel gave careful consideration to the training undertaken by you which is theoretical and has not been tested in clinical practice. You have not worked as a registered nurse since 2019 and therefore you have been unable to, at this time, demonstrate a strengthening of your practice.

Whilst the panel had before it a number of testimonials attesting to your honesty, good character and ability as a registered nurse, many of those testimonials predate these regulatory proceedings. In light of this, and given the misconduct found proved, the panel determined that it would be appropriate to give those testimonials only limited weight.

Given your limited insight, and lack of remediation, the panel could not be satisfied that should you encounter a similar environment again, your misconduct would not be repeated. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

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

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

Sanction

The panel has considered this case carefully and has decided to make a conditions of practice order for a period of 18 months. This order must be reviewed at 12 months. 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 Kennedy informed the panel that the sanction bid is that of a striking off order. He next highlighted what, in the NMC's view, were aggravating and mitigating factors in your case.

Mr Kennedy submitted that taking no action or imposing a caution order would not be an appropriate response given the circumstances of your case. In relation to a conditions of practice order, Mr Kennedy noted that the panel had previously determined that the misconduct found proved is capable of been remediated. However, he submitted that it is the NMC's position that a conditions of practice order would not be appropriate, due to the seriousness of the concerns in your case and given your seniority at the time the charges arose.

Mr Kennedy further submitted that a suspension order would not be a sufficient, appropriate or proportionate response given that the misconduct found proved was not an isolated incident and that your behaviour was a significant departure from the standards expected of a registered nurse.

In light of this, Mr Kennedy invited the panel to find that your actions are fundamentally incompatible with you remaining on the register, and allowing you to do so would undermine the public confidence in the nursing profession and the NMC as a regulator.

Mr Akers submitted that, given all the mitigating factors in your case, including the lapse of time since the allegations first arose, a caution order would be an appropriate disposal in this matter.

In the alternative, Mr Akers submitted that a conditions of practice order may be a proportionate and workable response, given the panel's findings that the misconduct found proved is capable of remediation. He suggested conditions requiring you to inform the NMC of any new employment, that you give a copy of the conditions to potential

employers, that you send a report from your line manager, mentor or supervisor to the NMC before any review hearing and that you write a further reflective statement.

Mr Akers reminded the panel that you qualified as a registered nurse 18 years ago and have worked within the care sector for over 27 years. He stated that during that time, no other concerns have ever been raised regarding your practice as a registered nurse. Mr Akers submitted that the fact you were a manager at the time the allegations arose, should not automatically result in a finding that there has been breach of trust in your case. He concluded by inviting the panel to find that imposing a striking off order would be grossly disproportionate.

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. It had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The charges relate to two different employments
- Your misconduct placed residents at a risk of harm
- The misconduct was not isolated and was repeated over a period of time
- At the time the charges arose, you were in a senior position

The panel also took into account the following mitigating features:

- At the outset of these proceedings you made admissions to some of the charges
- You have demonstrated some insight

- No previous concerns have been raised regarding your practice as a registered nurse
- You have completed some training in order to strengthen your practice since the allegations arose

The panel next 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 proportionate and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. It took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *…;*

- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. There is no evidence before the panel of any deep-seated attitudinal problem and it accepted that you would be willing to comply with conditions, particularly given your engagement with these proceedings. The panel determined that a conditions of practice order would protect patients during the period that they are in force and address the public protection concerns identified. It was of the view that it was in the public interest that, with appropriate safeguards, you should be able to return to practise as a nurse.

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

The panel considered that imposing a suspension order would be disproportionate given the particular circumstances of your case. It determined that the public interest concerns identified in your case, can be addressed by a conditions of practice order.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse. The panel determined that a fully informed member of the public would be satisfied by the imposition of a conditions upon your practice.

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 work with your line manager, mentor and/or supervisor to create a personal development plan (PDP). Your PDP must address the concerns about:
    a) Maintaining accurate clinical documentation;
    b) Effective communication;
    c) Making effective clinical decisions; and
    d) Carrying out effective risk assessments

2. You must meet with your line manager, mentor and/or supervisor on a monthly basis to discuss, reflect and provide evidence on the PDP in relation to the following areas of your practice:
    a) Maintaining accurate clinical documentation;
    b) Effective communication;
    c) Making effective clinical decisions; and
    d) Carrying out effective risk assessments

3. You must send a copy of your PDP to the NMC before any review hearing.

4. 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.

5. 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.

6. 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

7. 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.

8. 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

The period of this order is for 18 months.

After 12 months, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at the hearing
- Any up to date testimonials
- Any ongoing or up to date training
- An up to date reflective statement

This will be confirmed to you in writing.

Interim order

As the conditions of practice 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 conditions of practice sanction takes effect.

The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy who invited the panel to impose an interim conditions of practice order in order to cover any potential appeal

period. He submitted that such an order was necessary for the protection of the public and was otherwise in the public interest.

Mr Akers did not oppose the application.

Decision and reasons on interim order

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

The panel concluded that 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 allow for the possibility for an appeal to be made and determined.

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 are sent the decision of this hearing in writing.

That concludes this determination.