Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 29 August 2023 – Friday, 8 September 2023

Virtual Hearing

Name of Registrant:	**June Grant**
NMC PIN	99B0451E
Part(s) of the register:	Registered Nurse – Adult Nursing (March 2002)
Relevant Location:	West Midlands
Type of case:	Misconduct
Panel members:	Nicholas Rosenfeld (Chair, Lay member) Jillian Rashid (Registrant member) Stacey Patel (Lay member)
Legal Assessor:	Cyrus Katrak
Hearings Coordinator:	Dilay Bekteshi
Nursing and Midwifery Council:	Represented by Leonard Wigg, Case Presenter
Ms Grant:	Not present nor represented
Facts proved:	Charges 1b, 1c, 1h, 1j, 1k, 1l, 1n, 2a, 2b, 2c, 3, 4, 6, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 8 and 9
Facts not proved:	Charges 1a, 1d, 1e, 1f, 1g, 1i, 1m, 5, 10 and 11
Fitness to practise:	Impaired
Sanction:	Conditions of Practice Order (9 months)
Interim order:	Interim Conditions of Practice Order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Grant was not in attendance and that the Notice of Hearing letter had been sent to Ms Grant's registered email address by secure email on 20 July 2023.

Mr Wigg, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing sent by the NMC to Ms Grant's email address on 23 July 2023 provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Grant's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Grant has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

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

At the outset of the hearing, Mr Wigg made an application for parts of the hearing to be held in private on the basis that there would be reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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. The panel also referred itself to the NMC's guidance document CMT-10 *'Hearings in private and public'* (last updated on 8 August 2023).

Having heard that there will be reference to Ms Grant's [PRIVATE], the panel determined to hold those parts of the hearing in private. The panel was satisfied that this would protect Ms Grant's right to privacy and confidentiality, which outweighed the public interest in those matters being heard in public, and that all remaining matters of the hearing could be heard in public.

Decision and reasons on proceeding in the absence of Ms Grant

The panel next considered whether it should proceed in the absence of Ms Grant. It had regard to Rule 21 and heard the submissions of Mr Wigg who invited the panel to continue in the absence of Ms Grant. He submitted that Ms Grant had voluntarily absented herself.

Mr Wigg drew the panel's attention to the Case Management Form completed by Ms Grant on 25 April 2023, where Ms Grant explicitly stated that she would not be attending the hearing and would not have any representation. Additionally, Mr Wigg referred to a telephone call log between Ms Grant and the NMC Case Coordinator dated 26 July 2023. It was noted during the telephone call log that Ms Grant was asked if she wanted to attend the hearing or if she was happy for the panel to proceed, [PRIVATE].

Mr Wigg submitted that these documents indicate that Ms Grant had no intention of attending the hearing, [PRIVATE] and not the reason for her absence. Therefore, Mr Wigg contended that Ms Grant has waived her right to attend and suggested that the panel should proceed in her absence.

The panel accepted the advice of the legal assessor. The legal assessor referred the panel to the NMC guidance *'Proceeding with hearings when the nurse, midwife or nursing associate is absent'* (reference CMT-8 last updated on 13 January 2023).

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel determined to proceed in the absence of Ms Grant. In reaching this decision, the panel has considered the submissions of Mr Wigg and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Grant;
- Ms Grant has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Five witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, including the clients who need their professional services;
- The charges relate to events that occurred in 2019 and 2020;

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Grant in proceeding in her absence. The evidence upon which the NMC relies was sent to her at her registered address and she has made responses to the allegations. However, Ms Grant will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Grant's own decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.
In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Grant.

Details of charge

That you, whilst employed as the Home Manager of Jubilee Court ('the Home')

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    a. failed to carry out daily flash meetings.
    b. failed to keep accurate records of flash meetings.
    c. failed to ensure staff minutes were documented between January and March 2020
    d. failed to carry out regular walk arounds and checks in the Home
    e. did not ensure the correct complaints policy was displayed in the Home
    f. did not keep the "you said we did board" up to date
    g. failed to ensure adequate checks for patients without call bells

h. failed to update patients care plans
i. implemented your own supplementary charts which were not sufficiently detailed
j. failed to ensure that handover documents provided detailed information on patients' clinical needs
k. failed to ensure wound care plans were being used and/or were up to date
l. failed to ensure patients MAR/TMAR charts were up to date
m. failed to use ABC charts
n. did not implement condition specific care plans for at risk patients

2. Between April and June 2020, failed to appropriately manage and/or respond to one or more medication errors in the Home, in that you:
   a. did not carry out an adequate investigation
   b. did not maintain accurate records of the medication errors
   c. failed to implement measures to prevent repetition of the medication errors

3. Failed to carry out regular supervision with staff and/or failed to document that supervisions took place did not carry out regular supervision with staff and/or failed to document those supervisions took place

4. Failed to carry out a full induction of Colleague A

5. Allowed Colleague A to administer medication prior to completing the medication competency check.

6. On 18/19 March 2020, failed to carry out a safe admission of Service User A.

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
    a. failed to adequately monitor their weight
    b. failed to assess them for swallowing difficulties on a monthly basis
    c. failed to carry out monthly pain monitoring and /or record that monthly pain monitoring had been carried out
    d. did not take any action in relation to their MRSA diagnosis
    e. did not ensure appropriate levels of PPE were utilised in providing care to prevent cross-contamination
    f. failed to review their needs since their admission
    g. failed to provide care for a moisture lesion and skin tear on admission

8. Between November 2019 and April 2020, failed to make safeguarding notifications for one or more '*notifiable*' incidents in the Home.
9. Failed to implement the Home's infection prevention and control procedures for Covid-19.

10. Failed to maintain confidentiality by allowing patients 'check' charts to be posted on their bedroom doors.

11. Failed to meet the objectives under the Home's Improvements action plan.

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

Decision and reasons on application to amend the charge

The panel proposed an amendment in charge 3 in relation to repetition within that charge and following the panel raising this of its own volition, Mr Wigg, on behalf of the NMC, agreed. The proposed amendment was to delete “and/or failed to document those supervisions took place”. He submitted that it is essentially a repetition of the first part of the charge and removing it would not alter the essence or nature of the charge.

Proposed charge

3. Failed to carry out regular supervision with staff and/or failed to document that supervisions took place ~~did not carry out regular supervision with staff and/or failed to document those supervisions took place~~

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 also referred itself to the NMC guidance document entitled *‘how a charge becomes final’* reference PRE-2C (last updated on 23 June 2021)

The panel noted that the amendment does not alter the nature of the charge rather, it solely involves the removal of the repetition within the charge, as both parts essentially convey the same meaning. The panel therefore determined that such an amendment, as applied for, was fair and in accordance with the overarching objective to protect the public. The panel was satisfied that there would be no prejudice to Ms Grant and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, it being in the interest of justice to do so and consequently, the amended charges read as follows:

That you, whilst employed as the Home Manager of Jubilee Court (‘the Home’)

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    a. failed to carry out daily flash meetings.
    b. failed to keep accurate records of flash meetings.
    c. failed to ensure staff minutes were documented between January and March 2020
    d. failed to carry out regular walk arounds and checks in the Home
    e. did not ensure the correct complaints policy was displayed in the Home
    f. did not keep the “you said we did board” up to date
    g. failed to ensure adequate checks for patients without call bells
    h. failed to update patients care plans
    i. implemented your own supplementary charts which were not sufficiently detailed
    j. failed to ensure that handover documents provided detailed information on patients’ clinical needs
    k. failed to ensure wound care plans were being used and/or were up to date
    l. failed to ensure patients MAR/TMAR charts were up to date
    m. failed to use ABC charts
    n. did not implement condition specific care plans for at risk patients

2. Between April and June 2020, failed to appropriately manage and/or respond to one or more medication errors in the Home, in that you:
    a. did not carry out an adequate investigation
    b. did not maintain accurate records of the medication errors
    c. failed to implement measures to prevent repetition of the medication errors

3. Failed to carry out regular supervision with staff and/or failed to document that supervisions took place

4. Failed to carry out a full induction of Colleague A

5. Allowed Colleague A to administer medication prior to completing the medication competency check.

6. On 18/19 March 2020, failed to carry out a safe admission of Service User A.

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
    a. failed to adequately monitor their weight
    b. failed to assess them for swallowing difficulties on a monthly basis
    c. failed to carry out monthly pain monitoring and /or record that monthly pain monitoring had been carried out
    d. did not take any action in relation to their MRSA diagnosis
    e. did not ensure appropriate levels of PPE were utilised in providing care to prevent cross-contamination
    f. failed to review their needs since their admission
    g. failed to provide care for a moisture lesion and skin tear on admission

8. Between November 2019 and April 2020, failed to make safeguarding notifications for one or more '*notifiable*' incidents in the Home.

9. Failed to implement the Home's infection prevention and control procedures for Covid-19.

10. Failed to maintain confidentiality by allowing patients 'check' charts to be posted on their bedroom doors.

11. Failed to meet the objectives under the Home's Improvements action plan.

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

Background

Ms Grant was referred to the NMC on 10 July 2020 by the Priory Group (the Group). It is alleged that there were widespread concerns identified by Group surrounding the safe management of an older people's service that was designed to meet the needs of older people, dementia service users, and those with nursing needs. Ms Grant was the Home Manager at the time the concerns were raised. The allegations relate to:

i. Poor leadership skills, including failing to investigate medication errors and failure to manage staff effectively through induction and regular supervision;

ii. Concerns around Ms Grant's ability to ensure and maintain the requisite quality of patient care, to include the failure to review patients appropriately on admission and failure to complete walk around checks (daily and medication walk arounds) or escalate patient care failings to Safeguarding;

iii. Failure to keep clear, accurate and contemporaneous records; failing to keep a record of walk arounds, flash meetings and failing to complete care plans accurately;

iv. Failure to implement organisational Standard Operating Procedures (SOP) to support Infection Control in relation to Covid-19;

v. Failure to manage the Home in accordance with the corporate governance policies and procedures implemented by the Group for the care of service users' who were staying with them; and

vi. Failure to maintain patient confidentiality, by the non-confidential positioning of patient observation charts

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Wigg under Rule 31 to allow the written statement and exhibits of Witness 5 into evidence. Mr Wigg informed the panel that in March 2023, Witness 5 received an email from the NMC informing him that the hearing was scheduled for 25 August to 8 September 2023. However, Witness 5 did not reply until 26 July, explaining that he was on leave. The NMC then asked if Witness 5 could attend the hearing via video-link, to which he declined. The NMC asked if there were any other days he could attend, and Witness 5 stated that he would be available during the week commencing 25 September 2023. Witness 5's delayed response confirming his inability to attend the substantive fitness to practise hearing would therefore result in his oral evidence not being before the panel. The NMC therefore made an application to adduce his written evidence and associated exhibits into evidence before the panel by way of hearsay. However, Mr Wigg submitted that the NMC has taken reasonable steps to ensure attendance and had consulted with Ms Grant, who had no objections to Witness 5's statement and exhibits being admitted. Indeed, in the telephone call note between Ms Grant and the NMC on 26 July 2023, she stated *"it is fine…to read his statement".*

Mr Wigg reminded the panel that under Rule 31, the panel has the discretion to admit evidence in the proceedings, including hearsay evidence, as long as it meets the criteria of being relevant and fair. He further referred the panel to the NMC guidance on *'Evidence'* (reference: DMA-6) and the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

Mr Wigg submitted that Witness 5's testimony is not the sole and decisive evidence, and therefore, its exclusion would not meet the threshold for unfairness to Ms Grant. Additionally, Ms Grant has agreed for the statement to be admitted, and she is not present to challenge the evidence in any case. He submitted that not admitting the statement would prejudice the NMC, as it contains specific admissions made by Ms Grant during the disciplinary process. These admissions hold significant evidential value for the NMC, particularly regarding the number of charges. Without this evidence, the panel would be

deprived of important information regarding Ms Grant's admissions. Mr Wigg therefore invited the panel to admit the statement and exhibits of Witness 5 as hearsay.

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

The panel noted that Witness 5 had scheduled a holiday, which therefore made him unavailable for the hearing and that he was unwilling to attend via video-link. While the panel found this to be unsatisfactory position, this was a pre-planned period of annual leave, which coincided with the substantive fitness to practise hearing. It was also noted that the NMC made efforts to contact Witness 5, although they could have sent a follow-up email in between their initial email to Witness 5 in March 2023 and his reply in July 2023.

The panel considered the extent to which Ms Grant would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 5 to that of adducing his witness statement and associated exhibits.

The panel determined that Witness 5's evidence is not the sole and decisive evidence in support of the charges. Additionally, Ms Grant was on notice from 26 July 2023 that Witness 5 is being considered for admission by way of hearsay and that she had not raised any objections and agreed to it going in as evidence. There is no evidence of any fabrication in Witness 5's statement, and the panel noted that certain passages supported Ms Grant's case. It also noted that Ms Grant had been provided with a copy of Witness 5's statement and, as the panel had already determined that Ms Grant had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 5 and the opportunity of questioning and probing that testimony. The panel was aware that the admission of such evidence by way of hearsay should not be regarded as a routine matter. However, in these circumstances, the panel came to the view that it would be fair to admit the statement and exhibits of Witness 5 into evidence

but would give what it deemed the appropriate weight once the panel had heard and evaluated all the evidence before it.

Application for adverse inference

Mr Wigg in his closing written and oral submissions invited the panel to draw an adverse inference from Ms Grant's failure to give evidence at the final hearing.

The panel determined to draw no adverse inference from Ms Grant's failure to give evidence. In reaching its decision, the panel took into account the NMC guidance *'Engaging with your case'* in particular, under the heading *'Not giving evidence at the final hearing'* (reference: FtP-14). The guidance references that the Courts have held that panels shouldn't draw an adverse inference based on the failure to give evidence unless:

1. We've put forward sufficient evidence that the nurse, midwife, or nursing associate has been involved in misconduct or that their fitness to practise is impaired for some other reason.

2. The nurse, midwife or nursing associate has been given an appropriate warning that an adverse inference may be drawn if they do not give evidence. The nurse, midwife or nursing associate must be given an opportunity to explain why it wouldn't be reasonable for them to give evidence and, if it is found that there is no reasonable explanation, be given an opportunity to give evidence.

3. There is no reasonable explanation for the nurse, midwife, or nursing associate not giving evidence (for example, not giving evidence due to illness may be reasonable).

4. There are no other circumstances that would make it unfair to draw an adverse inference…

In relation to point 1, the panel was satisfied that the NMC has presented a *'prima facie'* case to answer. The panel acknowledged that Ms Grant was duly warned about the proceedings through the Notice of Hearing letter that was sent to her in July 2023.

As for points 2 and 3, it is apparent that Ms Grant clearly communicated on both 25 April 2023 and 26 July 2023 that she would not attend the hearing. The panel noted continued position of non-attendance in these communications. [PRIVATE], the panel noted that the CMF confirming her non-attendance predates the telephone call with the NMC on 26 July 2023. Given the indication of non-attendance in April and July 2023, it was open to the panel to conclude that at that time it may not have been her intention to attend these proceedings.

However, despite Ms Grant's ultimate non-attendance for the reasons she has provided to the NMC in July 2023, the panel had no reason to look behind these explanations [PRIVATE].

The panel had regard to all the circumstances in this particular case. [PRIVATE], it determined that, in the circumstances, it would be unfair to draw an adverse inference in this case.

Decision and reasons on application to amend the charge

The panel of its own volition, took the initiative to amend charges 1h, 1l, 3, and 7c under Rule 28. As such, the panel proposed the following amendments:

Charge 1h

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   h. failed to ensure patients care plans were updated.

Charge 1l

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   l. failed to ensure patients MAR and/or TMAR charts were up to date

Charge 3

3. Failed to ensure that staff had regular supervisions and/or failed to ensure that supervisions were documented.

Charge 7c

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
   c. failed to ensure pain monitoring was carried out and/or record that pain monitoring had been carried out

The panel invited Mr Wigg to make any representations on these amendments proposed by the panel. Mr Wigg did not express any objections to these amendments. The panel's intention behind these amendments was to reflect the evidence the panel had heard and to ensure fairness of proceedings to both the NMC and Ms Grant. The panel carefully assessed the potential impact of the amendments and concluded that the nature of the charges would remain the same, and there would be no injustice to Ms Grant. Consequently, the re-amended charges read as follows:

That you, whilst employed as the Home Manager of Jubilee Court ('the Home')

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    a. failed to carry out daily flash meetings.
    b. failed to keep accurate records of flash meetings.
    c. failed to ensure staff minutes were documented between January and March 2020
    d. failed to carry out regular walk arounds and checks in the Home
    e. did not ensure the correct complaints policy was displayed in the Home
    f. did not keep the "you said we did board" up to date
    g. failed to ensure adequate checks for patients without call bells
    h. failed to update patients care plans
    i. implemented your own supplementary charts which were not sufficiently detailed
    j. failed to ensure that handover documents provided detailed information on patients' clinical needs
    k. failed to ensure wound care plans were being used and/or were up to date
    l. failed to ensure patients MAR/TMAR charts were up to date
    m. failed to use ABC charts
    n. did not implement condition specific care plans for at risk patients

2. Between April and June 2020, failed to appropriately manage and/or respond to one or more medication errors in the Home, in that you:
    a. did not carry out an adequate investigation
    b. did not maintain accurate records of the medication errors
    c. failed to implement measures to prevent repetition of the medication errors

3. Failed to carry out regular supervision with staff and/or failed to document that supervisions took place did not carry out regular supervision with staff and/or failed to document those supervisions took place

4. Failed to carry out a full induction of Colleague A

5. Allowed Colleague A to administer medication prior to completing the medication competency check.

6. On 18/19 March 2020, failed to carry out a safe admission of Service User A.

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
    a. failed to adequately monitor their weight
    b. failed to assess them for swallowing difficulties on a monthly basis
    c. failed to carry out monthly pain monitoring and /or record that monthly pain monitoring had been carried out
    d. did not take any action in relation to their MRSA diagnosis
    e. did not ensure appropriate levels of PPE were utilised in providing care to prevent cross-contamination
    f. failed to review their needs since their admission
    g. failed to provide care for a moisture lesion and skin tear on admission

8. Between November 2019 and April 2020, failed to make safeguarding notifications for one or more '*notifiable*' incidents in the Home.

9. Failed to implement the Home's infection prevention and control procedures for Covid-19.

10. Failed to maintain confidentiality by allowing patients 'check' charts to be posted on their bedroom doors.

11. Failed to meet the objectives under the Home's Improvements action plan.

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

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 made by Mr Wigg on behalf of the NMC and Ms Grant's CMF and written reflections.

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: Operations Director for Priory Adult Care

- Witness 2: Regulatory Inspector for Priory Adult Care

- Witness 3: Peripatetic Manager at Priory Adult Care
- Colleague A: Deputy Manager at St Matthew's Care Home
- Witness 4: Quality Improvement Lead for Priory Adult Care

The panel also considered the hearsay evidence of Witness 5: Operations Director with Priory Adult Care.

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

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

Charge 1a

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   a. failed to carry out daily flash meetings.

This charge is found NOT proved.

The panel carefully considered the evidence presented to it, these included the Guide to Governance in Older People's Services for Home Managers and Deputy Managers, the Template for Flash Meeting Records, and the witness statements provided by Witness 2, Witness 3, and Colleague A. It was clear to the panel that there was an obligation to hold daily flash meetings.

The panel took into account the witness statement from Witness 2, who mentioned "gaps" in relation to the flash meetings: *“The 'gaps' referred to were days where the flash meetings had not taken place at all.”* However, the panel found this statement to be uncorroborated as there were no supporting documents to demonstrate the absence of these flash meetings.

The panel also considered the statement provided by Witness 3. According to Witness 3, there were concerns about the irregularity and improper documentation of the flash meetings: *“There should be a "flash meeting" at 10.30am or 11.00am. […] One of the wider areas of concern with the Registrant's management of the Home is that she did not hold these meetings regularly enough or record them correctly.”*

Furthermore, the panel considered the oral testimony of Colleague A, who stated that flash meetings were indeed held daily. Colleague A clarified that when the manager was not available, the meetings were conducted by herself or agency personnel.

The panel preferred Colleague A's evidence to that of the other witnesses on this point. Colleague A, who had experience working alongside Ms Grant, confirmed that the flash meetings were consistently conducted and recorded, albeit sometimes by different individuals: “*there were daily flash meetings every day when management was there– if manager was not there – it would be done by agency.*”

Given the evidence of Colleague A, the panel was not satisfied that daily flash meetings did not occur. The panel found Colleague A's evidence credible given that she was regularly working alongside Ms Grant. Although she contradicted Witness 2's claim of "gaps" in the meetings, this was not supported by documentation to substantiate such gaps. Therefore, the panel gave more weight to Colleague A's evidence and found charge 1a not proved.

Charge 1b

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    b. failed to keep accurate records of flash meetings.

This charge is found proved.

In reaching its decision, the panel took into account the Guide to Governance in Older People's Services for Home Managers and Deputy Managers, the Template for Flash Meeting Records, and Ms Grant's response. The panel was satisfied that there was an obligation to keep accurate records of flash meetings.

The panel took into account Ms Grant's reflective account. In her account, she mentioned that the monitoring of forms during the daily walkarounds or flash meetings was not recorded, as these forms primarily focused on issues within the home. She stated that she did not comment on this because the observation chart served as an indicator of everything being fine. In Ms Grant's reflective account, it states the following: *"We did not record the monitoring of the forms on the daily walkarounds or Flash as these forms were mainly concentrating on issues within the home and therefore I would not comment as we had the observation chart to give us an indication that all was fine."*

The panel noted Ms Grant's own admission that she failed to use these forms. While she admitted to this lapse, she contended that it did not compromise the safety of the Home as the information was recorded elsewhere.

Witness 3's evidence was also taken into account by the panel. Witness 3 stated in oral evidence that "*you could delegate flash meetings, but the expectation is that managers are accountable and responsible and need to know who is ill, who is deteriorating, you can give leadership and direction to the team".*

The panel found Witness 3's explanation of the importance of flash meetings and for them to be recorded as an essential management tool for the safety of the Home.

The panel considered the evidence of Colleague A who stated that the flash meeting forms were completed daily. However, in this instance it has decided to give greater weight to admissions given by Ms Grant herself nearer to the events that they were not completed.

The recording of flash meetings was vital for monitoring the well-being of residents, and a failure to record these would, in the determination of the panel, impact on the safe care to be provided to residents within the Home. Therefore, the panel found charge 1b proved.

Charge 1c

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    c. failed to ensure staff minutes were documented between January and March 2020

This charge is found proved.

The panel took all the evidence into consideration, including Ms Grant's job description and the oral and documentary evidence provided by Witness 2.

The panel carefully examined the job description, which clearly outlined Ms Grants responsibilities as a manager. According to the description, it states: "*Ensure that all documentation and nursing records are maintained and that a programme of meaningful activities is available to residents. Implement appropriate systems to ensure compliance with requirements."* The panel was satisfied that Ms Grant was expected to follow the requirements outlined in her job description and that this created an obligation to ensure that staff minutes were documented.

The witness statement of Witness 2 was also considered by the panel. Witness 2 highlighted the importance of taking minutes during staff meetings: "*[..] all staff meetings should have minutes and attendance listing as evidence for inspections. It is important that these minutes were being taken as they provide evidence that management are communicating with staff regarding the efficient running of the service and the quality and delivery of care. They also evidence that staff are being made aware of new policies and procedures, and monitoring staff wellbeing and training requirements".*

Additionally, the panel took into account Witness 2's statement, in particular: "*During my inspection on 04 and 05 March 2020 I saw that no minutes had been taken for staff meetings so far in 2020. This was evident from the absence of any form in the Home office".*

The panel recognised the importance of minutes being recorded in ensuring staff were aware of new policies and procedures from management.

Considering the evidence provided by Witness 2, who confirmed that no minutes were taken for staff meetings following an audit, the panel determined that the charge was proved. The panel considered that the lack of meeting minutes would have an impact on the safe management of the Home, as staff were not adequately informed about new policies and procedures, and this would impact on the safe management of the Home. Witness 2 also emphasised that minutes serve as evidence of effective communication between management and staff in ensuring the efficient operation and quality of care. Therefore, on the balance of probabilities, the panel found charge 1c proved.

Charge 1d

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   d. failed to carry out regular walk arounds and checks in the Home

This charge is found NOT proved.

In making its decision, the panel considered all the evidence, including the Guide to Governance in Older People's Services for Home Managers and Deputy Managers, as well as the oral and documentary evidence provided by Witness 2 and Colleague A. The panel was satisfied that there was an obligation on Ms Grant to carry out regular walk arounds and checks in the Home.

The panel took into account the witness statement of Witness 2, who states: "At *the time of my inspection none of the Quality Walk Arounds were being completed frequently or thoroughly enough to reassure me that the Home was meeting quality standards"*. The monitoring inspection was undertaken on 4 and 5 March 2020. It states, *"managers quality walk around appears to have been recently implemented from February 2020."*

However, the panel took into account the oral evidence given by Colleague A. Colleague A stated that Ms Grant conducted regular walk arounds every day in the morning, including environmental and safety checks on staff. In oral evidence Colleague A said: *"she did regular walk arounds, she did walk arounds every day in the morning before she went to the office, she did environmental and safety checks on staff. There was a form she needed to complete, and she did that every day".*

Colleague A stated that there was a form that needed to be completed, and Ms Grant fulfilled this requirement daily. The monitoring inspection was only conducted over a two-day period in March 2020. Colleague A was the Deputy Manager of the Home who worked with Ms Grant closely and regularly. The panel therefore preferred the evidence of

Colleague A. The panel was satisfied that Ms Grant did indeed perform walk arounds and checks every morning, as directly witnessed by Colleague A. As a result, the panel determined that on the balance of probabilities, charge 1d was not proved.

Charge 1e

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   e. did not ensure the correct complaints policy was displayed in the Home

This charge is found NOT proved.

The panel took all the evidence into consideration when reaching its decision, including the job description and the evidence provided by Witness 2. The panel was satisfied that there was an obligation on Ms Grant to ensure that the correct complaints policy was displayed in the Home.

The panel considered Witness 2's witness statement, which confirmed that the displayed policy was outdated, incorrect, and had the wrong company name (Amore). The panel accepted this evidence, however, the panel noted that the presence of an incorrect policy on the notice board does not necessarily prevent individuals from lodging complaints through other appropriate channels. It therefore determined that there was an obligation, Ms Grant fell short of adhering to this obligation, but that it would not necessarily impact the safe management of the Home.

The panel also took into account Witness 2's evidence, particularly their inspection on 4 and 5 March 2020, where it was confirmed that an incorrect policy was displayed. However, the panel concluded that this discrepancy did not have an adverse effect on the safe management of the Home. It was of the view that there were alternative processes in place for individuals to file complaints, which could have been brought to the attention of the staff. Based on these considerations, the panel determined that charge 1e was not proved.

Charge 1f

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    f. did not keep the “you said we did board” up to date

This charge is found NOT proved.

In reaching its decision, the panel considered the oral and documentary evidence presented by Witness 2 and Witness 4.

The witness statement of Witness 2, which highlights “*It is a CQC regulatory requirement for residents and relatives to be involved. […]* Witness 2 also stated, *"Even if this was not something the Registrant directly did herself, she should have ensured it was taking place. There is not a written policy that I can exhibit but it is a part of the responsibility of the Registered Manager to provide person centred care."* Additionally, the panel took into account the following information from Witness 2's statement, which states that the *“'You said, we did' board was out of date.”* The panel was satisfied that there was an obligation on Ms Grant to keep the ‘you said, we did’ board up to date.

However, the panel considered the oral testimony of Witness 4 who emphasised, *“flash meetings not recorded does not mean the home is not operating below standard, same with the ‘you said, we did’ board.”*

Whilst there was an obligation to keep the board up to date, and the evidence demonstrated that there was a failing in this respect, the panel determined that this failure would not have impacted on the safe management of the Home and therefore the panel found charge 1f not proved.

Charge 1g

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   g. failed to ensure adequate checks for patients without call bells

This charge is found NOT proved.

In reaching its decision, the panel considered the Guide to Governance in Older People's Services for Home Managers and Deputy Managers, as well as the oral and documentary evidence provided by Witness 1, Witness 2, and Colleague A. The panel was satisfied that there was an obligation on Ms Grant to ensure there were adequate checks for patients without call bells.

The witness statement of Witness 2 was taken into account, which emphasised the importance of reflecting residents' inability to use a call bell in their care plan and risk assessment. Witness 2 stated: "*If a resident is unable to use a call bell this should be reflected in their care plan and risk assessment I cannot produce these specific documents where this was lacking as I did not make copies or take away these records, and any notes created to help create the exhibited report have since been destroyed. These care plans should show why there is a risk and what the Home was doing to minimise this risk. The care plans that I saw in the Home during my inspection did not detail why residents were unable to use call bells, or what was being done to minimise risk".*

The panel also considered the responsibility of the Registered Manager, as outlined in Witness 2's statement, which highlighted Ms Grant's duty to ensure checks were in place for residents unable to utilise call bells and that documentation needed to be maintained. Additionally, Witness 2's statement emphasised that some residents would be unable to use a call bell to alert staff when they needed assistance. The absence of call bells and the need for checks on these residents were highlighted as necessary observations that

should be included in residents' care plans. The management of the Home would also be responsible for ensuring that all staff were aware of and implemented this procedure.

However, the panel took into account the oral evidence provided by Colleague A, who stated that new care plans were implemented, along with hourly safety checks: "*The call bells – we did new care plans and I think we did hourly safety checks and think the form was in the bedroom. We did a big piece of work on this with Quality Improvement Lead (QIL). I'm fully satisfied that there were safety checks and that the care plans were in place to support that."* The panel found Colleague A's evidence to be credible given the close working professional relationship between Ms Grant and Colleague A, the panel preferred her evidence.

Based on the evidence provided by Colleague A, which corroborated the implementation of safety checks for residents without call bells, the panel determined that charge 1g was not proved on the balance of probabilities.

Charge 1h

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   h. failed to ensure patients care plans were updated

This charge is found proved

In reaching its determination, the panel took into account the Care plan rewrite tracker of Clarence Unit in the Home, as well as the oral and documentary testimony of Witness 2 and Witness 4.

The panel took into account Witness 2's statement, where she highlighted issues related to residents at risk of choking. Witness 2 states: *“This issue refers to residents who were assessed as at risk of choking. If a risk is identified, the resident in question is referred to the Speech and Language Therapy Team ("SALT"). SALT would then do an assessment of the resident's diet and fluid intake. For residents with this kind of risk there may be a need to puree their diet, or add thickener to the fluids they are given so they do not choke. I cannot produce these specific documents or details of the residents where this was lacking as I did not make copies or take away these records, and any notes created to help create the exhibited report have since been destroyed.*

On my inspection I saw that the guidance from the SALT was not included in a resident's care plan. This could mean we are giving residents who should be on pureed diets hard food or fluids without thickener. This can put residents at increased risk of choking and even death.

It was the responsibility of the Registrant as the Home and Registered manager to ensure that the guidance of healthcare professionals like the SALT team was included in residents' care plans. Even if this was delegated to nursing staff, (I do not know whether it was or not) the Group's quality management tools should have been used to identify and address these issues before my inspection. These tools are the quality walk arounds as detailed in the Governance Guide (Exhibit SW/02).”

Witness 2's statement also drew attention to inconsistencies in care plans regarding the equipment to be used for residents who are unable to move themselves. This lack of clarity could lead to errors and potential harm to residents. Although Witness 2 did not have copies of specific documents or records to support her findings, the risk of confusion and improper handling of residents remained a significant concern.

The panel also considered the witness statement of Witness 4, who highlighted that care plans and risk assessments were not thoroughly reviewed and updated in accordance with the Group's processes. Witness 4 referred to the Group's Care Plan audit to demonstrate the proper protocol for reviewing and updating care plans.

Although the panel did not receive the source documents referred to by the witnesses, it was prepared to accept their evidence in respect of this issue. The matter was detailed in the report completed in March 2020 and has not been disputed by Ms Grant. Considering the corroborating evidence provided by Witness 4, both in their written and oral testimony, the panel concluded that care plans were indeed not being thoroughly reviewed and updated when there was an obligation on Ms Grant that they should have been.

Given the central role of care plans in properly managing the Home and ensuring the welfare of residents, the panel determined that this charge had been proved.

Charge 1i

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    i. implemented your own supplementary charts which were not sufficiently detailed

This charge is found NOT proved.

The panel took into consideration the witness statement provided by Witness 2, which states: "*The Registrant had implemented her own style of Supplementary Charts. Supplementary charts are located in the service users rooms, they are adjacent to the care plan, and record resident hygiene, fluid intake, repositioning, and any concerns with skin integrity, including body maps. These were not sufficiently detailed to meet the standards expected by the Group, for example in areas such as fluid monitoring. The Registrant had also discontinued some of the Group's processes and procedures designed to maintain quality, standards and safety*."

Next, the panel considered the oral evidence provided by Witness 4. Witness 4 mentioned that Ms Grant was attempting to reduce the level of detail on the form by consolidating a number of forms into one document she had used in a previous home. The witness stated that Ms Grant *"did not get approval for that"*. Although they lacked certain corporate details, these forms would still have been sufficient. However, the panel did not have the opportunity to examine these forms or compare them to a corporate governance form that would have contained the necessary level of detail. The NMC appear to be unclear about the obligation prohibiting the use of Ms Grant's own supplementary charts. Even if such an obligation existed, and Ms Grant failed in that obligation, given that the evidence was that these forms were sufficient, the panel determined that it did not impact on the safe management of the Home and therefore this charge is found not proved.

Charge 1j

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    j. failed to ensure that handover documents provided detailed information on patients' clinical needs

This charge is found proved.

In reaching its decision, the panel considered all of the evidence, including the Guide to Governance in Older People's Services for Home Managers and Deputy Managers, the Standard Operating Procedure Fluid Intake, as well as the oral and written testimonies provided by Witness 2 and Witness 4. The panel was satisfied that there was an obligation on Ms Grant to ensure that handover documents provided detailed information on patients clinical needs.

Firstly, the panel examined the witness statement of Witness 4, which highlighted the responsibility of the nursing or management team in ensuring regular updates: **"***The people making these updates should be the nursing or Management team, with management oversight The Governance Guide at Exhibit SW/02 also shows that the Registrant was for responsible for ensuring this took place…Handover documents were not being thoroughly or sufficiently completed. The expectation with handover documents is to ensure that each handover document has an overview of the clinical needs of each service user, The frequency of repositioning and dietary requirements were not always updated, these need to be updated weekly or when needs change."*

Further, the panel examined the witness statement of Witness 2, which emphasised the importance of recording residents' fluid intake throughout the day and monitoring it against their daily targets. The panel also noted that the fluid targets and '24 hour intakes' were not consistently recorded on the handover documents.

Taking into account the evidence provided by Witness 2 and Witness 4, the panel heard no evidence to the contrary. The panel determined that Ms Grant failed to ensure that the handover documents contained sufficient and detailed information. This lack of detail, especially regarding fluid charts, directly impacted the safe management of the home and compromised the level of care the residents should have received. Consequently, the panel found this charge proved.

Charge 1k

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   k. failed to ensure wound care plans were being used and/or were up to date

This charge is found proved.

The panel carefully considered all the evidence before it. Firstly, the panel took into account the Group Template for initial wound assessment and the internal inspection report conducted on 4 – 5 March 2020. Additionally, the panel considered the oral and documentary evidence provided by Witness 2. The panel was satisfied that there was on obligation to ensure wound care plans were used and/or were up to date.

In particular, the panel focused on Witness 2's witness statement, wherein she highlights the importance of proper documentation for pressure care and wound assessment. "*Documentation was created by the Group to ensure that pressure care or actual wounds are assessed."* She further states: "*… the Group's compliance helpdesk sends all such documentation to all service managers. Therefore, I would have expected her to ensure it's implementation within the Home. The ultimate responsibility for the delivery of care in the Home lay with the Registrant as the Registered Manager.*"

Regarding the internal inspection report authored by Witness 2, it was noted that the correct tools for wound assessment and dressing documentation were not being used. Instead, a care plan evaluation form was being utilised to track dressing changes. The report emphasised the need for correct tools to monitor residents' care and treatment.

The panel also took into account Witness 2's additional remarks about the absence of a measuring tool with the wound photos and the failure to include residents' details on such photos. It was noted that the wound care pack contains a measuring tape, which should have been used to accurately record the size of wounds in the photos.
In the absence of any evidence to the contrary, the panel accepted the evidence of Witness 2. The panel was also aware that photos taken lacked a measuring tool and were not being used correctly. Given the significance of wound care in an elderly care home, the panel determined that this matter would have impacted on both the care and safe management of the Home and its residents. The panel therefore found charge 1k proved.

Charge 1l

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
    l. failed to ensure patients MAR and/or TMAR charts were up to date

This charge is found proved.

The panel assessed all the evidence before it, including the Guide to Governance in Older People's Services for Home Managers and Deputy Managers, as well as the testimonies of Witness 2, Witness 3, and Colleague A. The panel was satisfied that there was an obligation on Ms Grant to ensure patients MAR/TMAR charts were up to date.

Firstly, the panel considered Witness 2's statement, which highlights the purpose of Topical Medicines Application Record (TMAR) charts in monitoring prescribed creams for residents' skin conditions and integrity issues. The panel also noted that Witness 2's identified gaps in the use and recorded frequency of applying prescribed creams during their inspection.

Additionally, the panel took into account Witness 3's statement, which mentions a policy mandating an internal "medication walkaround" that should be conducted twice a month by Ms Grant as the Home Manager. This procedure involves witnessing medication administration, checking the medication fridge and room temperatures, and reviewing the Medication Administration Record (MAR) charts.

Colleague A also provided oral evidence stating that MAR charts were checked daily/nightly. However, Colleague A stated that there were issues TMAR charts. She confirmed that they were not always completed. It should be noted that TMAR charts are used for recording topical medicine administration.

The panel noted Colleague A suggested that MAR charts were updated, and forms were filled out, but mentioned issues specifically with the completion of the TMAR charts. The panel determined that Ms Grant ensured that the individual MAR charts were kept up to date, but that the TMAR charts were not properly maintained. The panel was satisfied that the obligation on Ms Grant to ensure TMAR charts were kept up to date. Given the evidence by Colleague A that TMAR charts were not always completed and that the staff may be unaware of the creams being used, this would impact on the care provided to the residents and the panel therefore found charge 1l proved.

Charge 1m

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:

m. failed to use ABC charts

This charge is found NOT proved.

In reaching its decision, the panel considered the oral and documentary evidence presented by Witness 2 and Colleague A.

The panel carefully examined the witness statement of Witness 2, which emphasised the importance of using ABC charts to track residents' distress levels and identify triggers. According to Witness 2, staff should utilise these charts to monitor residents' well-being and alert the resident's GP or Community Psychiatric Nurse (CPN) if necessary. By monitoring changes and identifying patterns through the use of ABC charts, it becomes possible to determine if a resident's prescribed medication needs review. Additionally, care plans should detail known triggers and de-escalation techniques tailored to each individual resident. Witness 2 explained that ABC charts are essential for supporting this level of care and treatment and that it serves as a vital tool in maintaining the health and well-being of residents.

The panel also noted that Witness 2 said that during the inspection of the Home, it was observed that ABC charts were not being utilised. This particular concern pertains to residents living with dementia or dementia-like symptoms who experience episodes of extreme distress.

Upon reviewing the evidence, the panel found Witness 2's testimony to be somewhat vague regarding the non-use of ABC charts by Ms Grant. Witness 2 did not provide a specific example of when an ABC chart was not used, only stating they were not being generally employed.

Furthermore, Colleague A in her evidence stated that *“one resident had an ABC chart, it was very much in place”.* Colleague A mentioned having no knowledge of any incidents and stated that the charts were being utilised as they should be.

The panel found the evidence of Colleague A to be credible and reliable and preferred her evidence over that of the other witnesses. Given her position at the Home and her knowledge on this particular issue, on the balance of probabilities the panel found this charge not proved.

Charge 1n

1. Between November 2019 and April 2020 failed to ensure the safe management of a care home in that you:
   n. did not implement condition specific care plans for at risk patients

This charge is found proved.

The panel carefully considered Witness 2's oral and documentary evidence in making its decision.

The panel placed particular emphasis on Witness 2's statement, which highlighted the responsibility of Ms Grant (Home Manager) in ensuring the use of condition specific care plans: "*This would have come from the compliance helpdesk again, emailed straight to the Registrant as the Home manager. These special condition specific care plans have come into existence as a result of lessons learned in the wider Group. I do not know if there is a specific policy or SOP which mandates the use of these care plans, however I know that they were issued via the compliance helpdesk directly to the Registrant's email address at the same time as the managers of all the Group's services (I do not recall the exact date). Even if this was delegated to nursing staff (something I do not know whether it occurred or not), the Group's quality management tools should have been used to identify and address these issues before my inspection. I do not know if the Registrant ever asked nursing staff to use these care plans, I only know that on my inspection I could see that they were not being used."* The panel was satisfied that there was an obligation on Ms Grant to implement condition specific care plans for at risk patients.

The panel noted that Witness 2 expressed uncertainty regarding the existence of a specific policy or SOP mandating the use of these care plans. However, they observed during their inspection that the care plans were not being utilised, including those related to diabetes, dementia, and wound care.

Although the panel did not have access to a specific policy mandating the use of these care plans, it acknowledged that all patients require specific care plans for aspects of their care, especially when they are at risk. Despite the absence of a SOP, the panel determine it essential for nurses to ensure the implementation of condition-specific care plans. It recognised the importance of care plans in safeguarding the residents' best interests and ensuring appropriate care. In view of the evidence before it, the panel concluded that this charge is found proved.

Charge 2a

2. Between April and June 2020, failed to appropriately manage and/or respond to one or more medication errors in the Home, in that you:
   a. did not carry out an adequate investigation

This charge is found proved.

The panel carefully considered all the evidence before it, including the Priory Group Medication Management and Policy, the Priory Group Incident Management, as well as the oral and documentary evidence provided by Witness 2 and Witness 3.

The panel specifically took into account Ms Grant's role and responsibilities as a manager of the Home. In doing so, it considered the Priory Group Medication Management Policy, which states: *"23.6 The home manager will take responsibility for investigating all medication errors, or in their absence, the person in charge of the home will conduct the investigation."*

Additionally, the panel considered the witness statement of Witness 1, who emphasised that it was the responsibility of Ms Grant as the Home and Registered Manager to thoroughly investigate the error and take measures to prevent its recurrence, even if the tasks is delegated to home staff.

Furthermore, the panel considered the failure in addressing this charge and took into account Witness 1's statement, which highlighted that the error was discovered during an audit conducted by Witness 4 or Witness 3, rather than being identified by Ms Grant through proper management procedures such as medication walkarounds.

The audit conducted by Witness 3 revealed that from 17 April to 21 April 2020, the resident had only received one out of the three prescribed 50mg tablets daily, resulting in a deficiency of dosage and six unaccounted tablets. The MAR chart provides evidence of the prescribed dosage and the missing tablets. Witness 3 approached Ms Grant, requesting an investigation into this error.

In early May 2020, Witness 1 reviewed the investigation form and notification documents completed by Ms Grant following the error. These documents, submitted as Exhibit VHo/06, raised concerns as they only referred to an "agency nurse" as responsible for administering the wrong dose on 17 April 2020, disregarding the involvement of two other nurses employed by the Home – an agency nurse and Colleague A, the Deputy Home Manager. This factual inaccuracy was observed in the internal medication error investigation form, the safeguarding notification, and the CQC notification.

Ms Grant suggests in her reflective evidence that she was in the process of investigating some of the medication errors, identified following the audit on 22 April 2020 and had taken some actions in this respect. She explained that she was working through the errors, when she was suspended on 30 April 2020. However, the panel felt that this reflection misses the gravamen of the charge. Had Ms Grant been implementing the Group’s corporate governance policies, the medication error would have been identified before the internal audit. It is on this basis that the panel finds this charge proved.

Charge 2b

2. Between April and June 2020, failed to appropriately manage and/or respond to one or more medication errors in the Home, in that you:
   b. did not maintain accurate records of the medication errors

This charge is found proved.

The panel made its decision by considering all the evidence before it, including the Priory Group Medication Management Policy and the testimonies of Witness 1 and Witness 3.

Regarding the Medication Management Policy, it states in paragraph 3.3 that the home manager is responsible for monitoring and auditing medication, ensuring that the results of these audits are reviewed in the home's Governance Meetings.

Witness 1's witness statement provided important information, stating that they requested an investigation from Ms Grant and completion of the necessary forms and notification to the CQC. Witness 1 provided supporting evidence including the Group medication error investigation form and datix notification record created by Ms Grant. However, Witness 1 also noted that the investigation form lacked sufficient detail and evidence of follow-up and learning.

In reference to the specific medication error, Ms Grant claimed to have checked on the follow-up but there was no record of such actions. The minutes of the investigation with Ms Grant on 30 April 2020 confirmed this discrepancy. Ms Grant’s medication error investigation form for this error was considered insufficient and lacking detail by Witness 1.

Witness 3's statement further supported the case, explaining that due to Covid-19 restrictions, the responsibility of administering insulin had been transferred to the Home's staff. The staff used outdated notes from the District Nurses instead of the internal paperwork, resulting in an incorrect dosage of insulin for the resident. Witness 3 emphasised that this increased the risk for the resident's health.

The panel also reviewed the Medication Error Investigation dated 17, 18, 19, 21 April 2020. While one of the investigations seemed reasonably satisfactory, the panel acknowledged Witness 3's concerns about its completeness and the fact that it was not completed by Ms Grant.

Taking into account the testimonies of Witness 1 and Witness 3, along with the associated exhibits, the panel found the charge proved.

Charge 2c

2. Between April and June 2020, failed to appropriately manage and/or respond to one or more medication errors in the Home, in that you:

c. failed to implement measures to prevent repetition of the medication errors

This charge is found proved.

In reaching its decision, the panel considered the Priory Group Medication Management policy, the report by Witness 3 regarding all medication errors, and the oral and written evidence provided by Witness 3.

The panel took into account the Priory Group Medication Management policy, specifically highlighting paragraph 23.9, which states *"All medication errors should be reviewed during monthly Governance Meetings, to enable trends analysis to take place and, where required, appropriate action taken."* The panel was satisfied that there was an obligation on Ms Grant to implement measures to prevent repetition of medication errors.

Regarding the failure to implement measures to prevent repetition of medication errors, the panel carefully examined the witness statement of Witness 3. Witness 3 stated that the nurse responsible for the error had started on the same day as Witness 3 and explained that the nurse was undergoing her induction. Witness 3 was shocked to witness the nurse administering medication without sufficient training or support. Ms Grant initially defended the nurse's role but later acknowledged that it was inappropriate for the nurse to be doing the medication rounds. Witness 3 expressed concerns about Ms Grant's response that the responsibility for medication errors lay solely with the nurses. Witness 3 also mentioned Ms Grant's perception of having an overwhelming workload and expressed that Ms Grant should have sought support from the Operations Director or the Quality Improvement Lead if needed.

The panel took into account the Medication Error Investigation for Service User A dated April 17, 18, 19, 21 2020 where Ms Grant identifies in the section how to prevent such errors, specifically mentioning "boots training."

The panel also had regard to the evidence of Witness 5. During the course of his disciplinary hearing with Ms Grant on 22 June 2020 where she specifically asked about her failure to investigate the medication errors, it was stated: *"she also confirmed that she had not taken any further action such as re-training or suspending staff on medication duty."* Ms Grant went on to admit that *"she had not done the follow up or the re-training of staff after these medication errors."* The panel therefore finds this charge proved by way of admission.

Charge 3

3. Failed to ensure that staff had regular supervisions and/or failed to ensure that supervisions were documented.

This charge is found proved.

In reaching its decision, the panel took into account the guidelines provided by the Priory Group Older People's Governance Guide, which included staff supervision requirements. Additionally, the panel examined Ms Grant's job description, which outlined her responsibilities as a Home Manager. Lastly, it carefully considered the oral and documentary evidence provided by Witness 1.

In particular, the panel focused on Ms Grant's role as a Home Manager and took into consideration the witness statement provided by Witness 1. According to Witness 1, it is the responsibility of Ms Grant to conduct supervisions and ensure that staff members are well trained and supported. This requirement is explicitly stated in the job description for the position of a Home Manager. The panel was therefore satisfied that there was an obligation on Ms Grant to carry out regular supervisions with staff and document that the supervisions took place.

The panel then carefully analysed the failure identified in the charge. Once again, it considered the statement of Witness 1. Witness 1 stated that in early May 2020, she discovered a lack of evidence indicating that one-on-one supervisions with staff were being conducted as per the organisation's policy. This discovery was made by reviewing employee files.

The panel also considered Ms Grant's job description. According to the job description, Ms Grant is expected to "*Develop strong working relationships with HR and other support functions to ensure the Home management and staff are inducted, trained, motivated and supported to achieve company standards and the highest levels of care and customer service"* The panel also noted that Witness 1 stated in their oral evidence that although the home manager can delegate supervision tasks, they are still responsible for the necessary paperwork.

After careful consideration of all the evidence presented, the panel concluded that this charge against Ms Grant is proved. This conclusion is based on Ms Grant's job description, which clearly outlines her obligation to fulfil the supervisory responsibilities and Witness 1's evidence that there was a lack of evidence indicating that one to one supervisions with staff were being conducted after May 2020. The panel therefore found this charge to be proved.

Charge 4

4. Failed to carry out a full induction of Colleague A

This charge is found proved.

In reaching its decision, the panel took into account Ms Grant's job description and the evidence provided by Witness 1 and Colleague A.

The panel examined Ms Grant's job description, which clearly stated her obligation as a manager to conduct a full induction for staff: *"Develop strong working relationships with HR and other support functions to ensure the Home management and staff are inducted, trained, motivated and supported to achieve company standards and the highest levels of care and customer service."* The panel also took into account the oral testimony of Colleague A, who asserted that Ms Grant's held overall responsibility for the induction process. The panel was therefore satisfied that there was an obligation on Ms Grant to carry out a full induction of Colleague A.

Additionally, the panel reviewed a witness statement from Colleague A, wherein she mentioned receiving an induction pack but expressed that it did not provide a complete and thorough introduction to her role. She acknowledged that several factors contributed to this, and that Ms Grant was not solely to blame.

Colleague A specifically stated that she was not fully inducted in areas such as corporate procedures, regional protocols, local operations, the running of the service, communications, and her own responsibilities in leading the team. However, she did mention that Ms Grant made efforts to revisit certain aspects of the induction, although these were not formally documented.

The panel noted that Colleague A's induction process was not solely dependent on Ms Grant. She acknowledged that while Ms Grant could not provide a full induction, she did what she could under the circumstances. Colleague A also accepted that the overall responsibility for induction lay with Ms Grant, even during periods of her absence, such as annual leave. During the course of her oral evidence, Colleague A stated to the panel *"I did not receive a full induction".* Based on the evidence of Colleague A, which the panel determined to be both credible and reliable, the panel found, on the balance of probabilities that, Ms Grant had an obligation to carry out a full induction and that she failed to induct Colleague A fully. The panel therefore find this charge proved.

Charge 5

5. Allowed Colleague A to administer medication prior to completing the medication competency check.

This charge is found NOT proved.

In reaching its decision, the panel evaluated all the evidence. Firstly, the panel examined the Management of Medications in Care Homes for Older People document. Additionally, the panel carefully reviewed the oral testimony and documentary evidence provided by Witness 1 and Colleague A.

The panel took specific note of the Management of Medications in Care Homes for Older People, which emphasises the home manager's responsibility for implementing medication policies, ensuring that all colleagues administering medications are adequately trained and competent: "*Para 3.1 The home manager is responsible for implementing this policy within the home and for ensuring all colleagues who administer medications have been trained and are competent to do so. This responsibility includes ensuring that the induction programme for trained colleagues is tailored to the needs of the service; the establishing of regular (at minimum, annual) competency assessments and the development of a robust training programme specific to the needs of the service."*

Furthermore, the panel carefully considered Witness 1's statement. According to Witness 1, Colleague A produced a discrepancy in her medication competency check. Colleague A began her role on 14 October 2019, but the competency check is dated 11 November 2019. Therefore, Colleague A was administering medication without having completed the necessary check between those dates, as evidenced by MAR charts from that period.

It is important to note that the panel encountered some challenges with the evidence presented for Colleague A's Medication Competency Check. The document provided was incomplete, consisting of only one page out of a nine-page form. Therefore, the panel found this evidence to be unclear and inconclusive.

In addition, Colleague A's statement was considered by the panel. Colleague A recalled assisting with medication administration when the home was understaffed, but never without the presence of Ms Grant or another nurse. Colleague A said that she was never alone until her own competency was signed off, and she only provided support to nurses during medication administration, for example, providing patients with drinks to take their medication.

The panel found Colleague A's testimony to be more credible and reliable and preferred her evidence. Indeed, when Colleague A gave evidence to the panel she stated *"I was supporting the nurse during the medications. I was never on my own until I was signed off on my competencies."* The panel therefore found charge 5 not proved.

Charge 6

6. On 18/19 March 2020, failed to carry out a safe admission of Service User A.

This charge is found proved.

The panel carefully considered the evidence provided by Witness 5 in reaching their decision. Of particular significance was the witness statement of Witness 5, which stated that Ms Grant admitted responsibility for the failure to conduct a safe admission for Service User A. This admission was also documented in the hearing outcome letter, where it was recorded that Ms Grant took full responsibility for the errors made and acknowledged that it was an oversight on their part. The panel was satisfied that there was an obligation on Ms Grant to ensure the safe admission of Service User A.

The panel determined that the allegation of the failure to conduct a safe admission was upheld based on Ms Grant's admission of oversight. Although the exact documents used to establish the inadequacy of the admission were not recalled, they were included in the investigation report.

Additionally, the panel reviewed the hearing outcome letter dated 26 June 2020 following the disciplinary hearing on 22 June 2020 which emphasised Ms Grant's full responsibility for the errors made and their acknowledgment of the oversight. Despite understanding the demands Ms Grant faced during that period, Witness 5 highlighted that the admission had placed Service User A in a vulnerable position, potentially resulting in serious ill health. As a Registered Manager, Ms Grant should have ensured the safe admission of Service User A.

Ms Grant did offer a mitigating factor, explaining that they had been struggling to cope with the demands of their role at the time. While the panel did have sight of the pre-admission for Service User A, it also considered the admission made by Ms Grant during the investigation process on 22 June 2020. Although Ms Grant denied the charge in the CMF, the panel gave weight to the earlier and unequivocal admission made by Ms Grant. The panel therefore found this charge proved based on this admission.

Charge 7a

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
   a. failed to adequately monitor their weight

This charge is found proved.

In reaching its decision, the panel thoroughly considered the Weight Management Standard Operating Procedure, as well as the testimony provided by Witness 1.

The panel considered Ms Grant's role as a manager and her responsibility to ensure sufficient care was provided to Service User A. Witness 1's statement was taken into account, which emphasised the importance of monitoring residents with significant weight loss in consultation with their GP, as outlined in the Group's SOP. The panel was therefore satisfied that there was an obligation on Ms Grant to monitor the weight of Service User A who was end of life notwithstanding that the panel heard evidence from Colleague A that it would not be necessary to be weight someone in these circumstances.

The panel examined the specific failure by Ms Grant as outlined in the charge. The panel noted that during Witness 1's review and subsequent investigation into Ms Grant, it was revealed that Service User A had been admitted to the Home on 19 March 2020, but was not weighed again until 29 May 2020. This is in direct contradiction to the Malnutrition Universal Screening Tool and the weight management SOP, which clearly state that Service User A should have been weighed weekly. Witness 1 also noted that there were no other documents indicating Service User A's weight during this time period. Furthermore, the panel took note of Witness 1's efforts to address this issue with the Clinical Lead for the Home who confirmed the importance of weighing Service User A but could not confirm if it had been done. Witness 1 also outlined that this neglect of duty by Ms Grant, both as the nurse who admitted Service User A and as the Home Manager responsible for enforcing quality of care, is clearly outlined in her job description and the Governance Guide.

Upon careful consideration of Witness 1's evidence, the panel concluded that Ms Grant indeed failed to follow up on Service User A and failed to ensure adequate care was carried out in that Ms Grant did not monitor the weight of Service User A. Therefore, the panel found charge 7a proved.

Charge 7b

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
   b. failed to assess them for swallowing difficulties on a monthly basis

This charge is found proved.

In reaching its decision, the panel considered the evidence provided by Witness 1. This included the witness statement, which presented a swallowing difficulties risk assessment mandated by the weight management SOP for residents like Service User A. The panel was satisfied that there was an obligation on Ms Grant to assess Service User A's swallowing difficulties on a monthly basis.

Furthermore, the panel carefully examined the failure of Ms Grant as described in the charge. Witness 1's stated that Service User A was not assessed for swallowing difficulties in April 2020, despite the monthly evaluation requirement stated in the Governance Guide produced by Witness 2. Witness 5 also states that Ms Grant did not ensure adequate standards of care as both the nurse who admitted Service User A and the Home Manager responsible for maintaining the quality of care provided within the Home and ensuring adherence to processes. These responsibilities were clearly laid out in Ms Grant's job description and the Governance Guide.

With regards to the swallowing difficulties risk assessment for Service User A dated 19 March 2020, the panel observed that there was no assessment conducted in April 2020. According to Bullet point 5 in the Swallowing difficulties risk assessment document, it is mandatory for all residents in Adult Care Older People Services to have a risk assessment completed within 24 hours of admission and for reviews of risk assessments and care plans to take place monthly. The panel therefore determined that Ms Grant failed in her obligation to carry out the required assessment in April 2020, as stated in the evidence. Therefore, the panel found this charge to be proved.

Charge 7c

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
    c. failed to ensure pain monitoring was carried out and/or record that pain monitoring had been carried out

This charge is found proved.

In reaching its decision, the panel carefully considered the swallowing difficulties risk assessment for Service User A and considered both oral and documentary evidence provided by Witness 1.

The panel took into account the obligation on Ms Grant, specifically examining Witness 1's witness statement, which clearly states that the care plan includes the monitoring of pain. Furthermore, the panel also examined the Swallowing difficulties risk assessment for Service User A, which explicitly states that the Abbey Pain scale should be utilised to determine pain levels. Based on this documentation, the panel concluded that Ms Grant had an obligation to carry out the monitoring.

In assessing the evidence regarding the failure in the charge, the panel carefully considered Witness 1's witness statement. Witness 1 states that their review of the file found no evidence of pain monitoring or documentation of the use of the Abbey Pain Scale. As supporting evidence, Witness 1 provided an example of the Abbey Pain Scale documentation. Witness 1 further concluded that Ms Grant did not uphold adequate standards of care, and that she should have taken responsibility for ensuring quality of care and adherence to processes, as outlined in Ms Grant’s job description and the Governance Guide.

The panel acknowledged the importance of monitoring pain in end-of-life care and took into consideration Witness 1's testimony. Based on the evidence presented, the panel determined that it is more likely than not that Ms Grant failed to conduct monthly pain monitoring and record-keeping. The panel therefore found this charge proved.

Charge 7d

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
   d. did not take any action in relation to their MRSA diagnosis

This charge is found proved.

The panel reached its decision by considering all of the evidence, including the minutes of investigation meeting with Ms Grant on 30 April 2020 and Witness 1's oral and documentary evidence.

Initially, the panel addressed whether Ms Grant had the responsibility of ensuring adequate care for Service User A in relation to their MRSA diagnosis. To evaluate this, the panel reviewed Witness 1's statement, which highlighted the issue. According to Witness 1, during their review of the file on 3 May 2020, it was discovered that Service User A had been diagnosed with Methicillin-Resistant Staphylococcus Aureus (MRSA), a superbug infection, as recorded on their admission document.

The panel also took into consideration Witness 1's statement, which stated that there was no mention of MRSA in the care plan or risk assessment. This meant that no measures were in place to mitigate the risk as it was not documented. The panel referred to Witness 1's statement and the pre-admission assessment form for Service User A, dated 18 March 2020. Notably, under the heading of "history of long-term infection," the form indicated a date next to MRSA (30 January 2020), which indicated that the service user had a history of long-term infection. This document revealed Ms Grant's failure to ensure a safe

admission for Service User A. The service user's pre-admission records confirmed the MRSA diagnosis, while the absence of MRSA in the care plan or risk assessment demonstrated a probable lack of risk mitigation measures. Consequently, the panel concluded that this charge is proved.

Charge 7e

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
    e. did not ensure appropriate levels of PPE were utilised in providing care to prevent cross-contamination

This charge is found proved.

In reaching its decision, the panel took into account the oral and documentary evidence of Witness 1's.

Witness 1's statement highlighted the importance of 'barrier nursing' for individuals with MRSA, emphasising the requirement for full Personal Protective Equipment (PPE) even before the Covid-19 pandemic. Witness 1 further states the absence of any mention of MRSA in the care plan or risk assessment, indicated a lack of measures in place to mitigate the associated risks.

The panel acknowledged that no additional evidence, such as a policy, supported the obligations mentioned by Witness 1. The panel noted that Service User A had been identified as having MRSA since January 2020, yet there was no care plan specifying the use of appropriate PPE for barrier nursing by nurses when providing care for this individual. The absence of such a care plan was deemed crucial by the panel.

Witness 1's assertion that there was no mention of MRSA in the care plan or risk assessment, which would have addressed the risk of cross-contamination, was deemed credible and reliable by the panel. As the Home Manager, it was determined to be Ms Grant's responsibility to ensure the implementation of ‘barrier nursing’. Considering these factors, in this respect, the panel found Witness 1's testimony to be credible and reliable. It therefore found this charge proved.

Charge 7f

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
   f. failed to review their needs since their admission

This charge is found proved.

The panel considered the evidence of Witness 1, particularly her statement regarding the lack of a review, discussion in flash meetings, and being appointed as the "resident of the day" in order to highlight clinical risk, following her visit to the Home on 3 May 2020. According to the resident's list provided it was evident that Service User A had not been included in this document, despite being admitted on 20 March 2020. This meant that Service User A should have been designated as the "resident of the day", at least once if not twice, during their time at the Home. These observations were included in the investigation report, highlighting the discrepancy in the treatment of Service User A.

Having found charges 7a, 7b, 7c and 7d proved and in consideration of the evidence before it, the panel determined, on the balance of probabilities, that this charge was also proved.

Charge 7g

7. Failed to carry out follow up care to Service User A and/or in the alternative ensure adequate care was carried out to Service User A in that you:
   g. failed to provide care for a moisture lesion and skin tear on admission

This charge is found proved.

Upon reviewing the information, the panel took into account the body map for Service User A dated 19 March 2020 and the oral and documentary evidence provided by Witness 1.

When examining Ms Grant's obligations, the panel took into account Witness 1's. Witness 1 highlighted the importance of ongoing monitoring and assessment of skin integrity, particularly wound management. Witness 1 referenced the Wound Management Policy, which was developed by Witness 2. Witness 1 said that it was the responsibility of both Ms Grant as the nurse who admitted Service User A and as the Home Manager to ensure that the correct quality processes, including wound management, were followed. The Governance Guide and Ms Grant's job description further corroborated this obligation.

Additionally, the panel considered the evidence concerning the failure outlined in the charge. It considered the Witness 1's statement, which mentioned that no further wound care documentation or an updated body map for Service User A was found during their review on 3 May 2020. Witness 1 produced a body map dated 19 March 2020 which revealed the existence of cuts but not the moisture lesion on admission. Witness 1 said that body maps are essential for documenting changes to skin integrity and emphasised the importance of monitoring and updating them as necessary. Furthermore, a pressure area risk assessment for Service User A was not updated after 31 May 2020, despite the expectation for monthly assessments.

The panel considered the body map for Service User A dated 19 March 2020 and the supporting evidence presented by Witness 1. Based on the evidence, the panel agreed with Witness 1's assessment that Ms Grant failed to provide appropriate care for the moisture lesion and skin tear following admission. It therefore found charge 7g proved.

Charge 8

8. Between November 2019 and April 2020, failed to make safeguarding notifications for one or more '*notifiable*' incidents in the Home.

This charge is found proved.

In reaching their decision, the panel took into account Ms Grant's job description, an email sent from Witness 4 to Ms Grant on 8 April 2020, and the oral and documentary evidence of Witness 4 and Witness 5.

The panel focused on Ms Grant's responsibility as a manager to report on safeguarding issues. It had particular regard to Witness 5's statement, which explains that notifiable events must be reported to the CQC as a part of the service's registration agreement. These events encompass incidents such as deaths or injuries within the service. Witness 5 also highlighted that the Group's Quality Improvement Team ensures all services implement the required quality assurance processes.

In addition, the panel reviewed Ms Grant's Job Description, which outlines her obligations "*Ensure that the regulatory bodies' standards are achieved and that all staff are trained to this level…Ensure that all documentation and nursing records are maintained and that a programme of meaningful activities is available to residents. Implement appropriate systems to ensure compliance with requirements."* The panel was therefore satisfied that there was an obligation on Ms Grant to make safeguarding notifications.

The panel then examined Ms Grant's failure to fulfil the obligations outlined in the charge. It referred to Witness 5's statement, where Ms Grant acknowledged during the hearing that she knew how to report to the CQC and the importance of doing so. Witness 5, further states: "*The fact that these notifications had not been submitted within 48 hours as required by the CQC and these were notifications of incidents of significant risk of harm. It was the responsibility of either the Home Manager or the Deputy Manager to report events to the CQC. However, as the CQC Registered Manager, I held the Registrant ultimately responsible for these events not being reported."*

The panel was satisfied that the Home Manager or Deputy Manager should attend to these reports, and as the CQC Registered Manager, Ms Grant was ultimately responsible. This is in line with her job description.

Witness 4's statement was also considered, which included an email highlighting six incidents that should have been reported to the CQC and Safeguard but were not. This email, dated 8 April 2020, prompted a more comprehensive analysis of incidents at the Home from October 2019 to May 2020. The analysis, presented as analysis of incidents in the Home by Witness 4, uncovered 20 reportable incidents that were not reported to the relevant authorities. The Home's accidents and incidents file was found in the Manager's office.

The panel found Witness 5's evidence credible and reliable and agreed that Ms Grant was aware of her obligation to make the notifications. It also took into account the email sent by Witness 4 on 8 April 2020, confirming safeguarding concerns between January and March 2020. Three specific safeguarding concerns were identified by the panel, and there was no evidence contradicting Witness 4's professional opinion. Therefore, the panel found this charge proved.

Charge 9

9. Failed to implement the Home’s infection prevention and control procedures for Covid-19.

This charge is found proved.

In reaching their decision, the panel took into account the laundering of colleague uniforms document, a management report created by Witness 4 on 15 March 2020, and the evidence of Witness 1, Witness 3, Witness 5, and Colleague A.

The panel first examined Ms Grant's obligation as outlined in the charge. It took into account Witness 5's statement, which indicated that all home managers were required to compile a file containing up to date Covid-19 infection prevention and control procedures in order to brief staff. This was part of the daily update calls conducted by Group's Operations Directors with Home managers. Furthermore, the panel considered the statement of Witness 1, which mentioned a policy on laundering of colleague uniforms that was implemented on 20 April 2020. According to this policy, staff should arrive at work in their own clothes and change into their uniforms on-site.

Next, the panel examined the evidence supporting Ms Grant's failure in relation to the charge. It took into account Witness 5's statement, where it was confirmed that Ms Grant had not set up the required file containing Covid-19 procedures.

Additionally, the panel heard evidence from Witness 3 and Colleague A, who stated that staff members were attending work in their work uniforms.

The panel reconsidered Witness 1's statement, which highlighted that staff members were unaware of the Covid-19 SOPs, including the proper laundering of uniforms. Witness 1 recalled holding meetings on 1 and 6 May 2020 to discuss the Covid-19 procedures that should have been implemented in the Home. There were no records of any previous meetings regarding Covid-19 or the SOPs. Staff members confirmed to Witness 1 and Witness 3 that they were unaware of the SOPs and the requirements for uniform washing.

Additionally, Colleague A in oral evidence told the panel that Ms Grant had recently returned from leave, enforced the use of PPE, and handled the situation well. However, staff members were smoking outside without discarding their mask, and Colleague A acknowledged that Ms Grant could not be everywhere at once and that staff members had their own accountability.

The panel noted that Ms Grant failed to create a Covid-19 folder with updates and that staff members were unaware of the SOPs and the requirements. Based on the testimonies of Witness 1 and Witness 3 regarding staff members' lack of awareness of the SOPs, particularly regarding uniform washing, and the observation that masks were being worn into the Home after being worn outside after smoking, as well as staff members wearing uniforms to and from work. The panel therefore determined that Ms Grant failed to implement the Home's infection prevention and control procedures for Covid-19 and found charge 9 proved.

Charge 10

10. Failed to maintain confidentiality by allowing patients 'check' charts to be posted on their bedroom doors.

This charge is found NOT proved.

In reaching this decision, the panel considered the Home Data Protection Policy, as well as the evidence provided by Witness 3 and Witness 4.

The panel took into account the witness statement of Witness 3, who expressed concern about the placement of the charts on the bedroom doors. The witness highlighted that these charts contained confidential information regarding the residents, which could be viewed by people in the corridor. Moreover, considering the presence of Covid-19 infections in the Home, the witness emphasised the risk of transmission when multiple people handle the charts without practicing proper hand hygiene. The witness had previously brought this issue to the attention of Ms Grant.

Additionally, the panel reviewed the witness statement of Witness 4, who stated that Ms Grant believed the charts needed to be displayed outside the doors as reminders for staff to keep them up to date. However, Witness 4 said that keeping the supplementary charts outside the rooms breached data protection regulations and that Ms Grant should have ensured they were being completed correctly in alternative ways.

During the oral evidence, Witness 4 indicated that the folders were not necessarily confidential simply because they were in the rooms, as they were not secured. This meant that anyone could enter the room and access the folders. The panel considered this information and concluded that since the folders were not confidential in the first place, their placement outside the rooms did not result in a failure to maintain confidentiality. Consequently, the panel found it not proved, based on Witness 4's testimony and her response to the panel, that there was no breach of confidentiality, as the information was not necessarily secure in the first instance. The panel therefore found charge 10 not proved.

Charge 11

11. Failed to meet the objectives under the Home's Improvements action plan.

This charge is found NOT proved.

In reaching its decision, the panel took into account the Home Action Plan and Monitoring Framework created on 4 June 2020, as well as Ms Grant's response bundle and the evidence provided by Witness 4.

Regarding Witness 4's statement, the panel noted that all of the Group's services have an action plan. While the plan is for the Home in general, Ms Grant, being the Home Manager, was responsible for implementing many of the action points and communicating progress to the team.

Furthermore, the panel reviewed Ms Grant's response bundle, in which she states: **"***The action plan was already in place when I took over the home in 2018, we had either monthly or fortnightly reviews depending when the O.D and the clinical Director were available. When the actions were completed they were turned to green and archived within the plan My self, Deputy and the Quality lead were responsible for the action plan, Every audit i.e fire, Health & Safety, medication etc were all added. I was often told how well we were doing on the plan. There were times when it was more difficult to work on the plan but this was discussed at the reviews for example when I did not have a deputy for 6 months, but I always had the plan open and worked on it when I had the time. I would be honest when I struggled to complete actions within a time frame and the time would be extended*."

After careful consideration, the panel thoroughly examined the Home Action Plan and Monitoring Framework created on 4 June 2020. It observed that it is a living document that evolves over time, with new matters and issues being added based on various audits. Some objectives had been marked as completed in green, while many were still in progress (indicated by amber) or yet to be done (signified by red). Importantly, there was no specified end date for the completion of objectives. It was clear to the panel that this document was being worked on and progressed by Ms Grant as new issues were being added. Given that there was evidence that the action plan was being progressed, the panel determined that Ms Grant was not failing to meet the objectives under the Home's improvement action plan. This was an ongoing process which Ms Grant was progressing over time. The panel therefore determined that charge 11 is not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Ms Grant's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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, Ms Grant's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Mr Wigg referred the panel 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 Wigg invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code) in making its decision. Mr Wigg referred the panel to the individual charges found proved and identified the specific, relevant standards where Ms Grant's actions amounted to misconduct. He submitted that each individual charge constitutes serious professional misconduct.

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

Mr Wigg referred the panel to the evidence provided by Ms Grant. This includes her reflections using the Gibbs model, certificates, and a reference from her previous employer, Four Seasons Health Care. However, Mr Wigg submitted that these documents do not fully address the specific concerns. Mr Wigg further submitted that Ms Grant's reflections fail to demonstrate any remediation of her practice. Consequently, Mr Wigg submitted that there is no compelling evidence to suggest that Ms Grant has addressed her managerial shortcomings and remediated her practice. Mr Wigg submitted that that Ms Grant's impairment is evident based on the proved facts, which encompass a range of failures including inadequate record-keeping, failures in upholding policies, and clinical failures.

Mr Wigg submitted that the charges are serious and wide reaching including managerial responsibilities. Mr Wigg therefore invited the panel to take the view that Ms Grant's fitness to practise is currently impaired.

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

Decision and reasons on misconduct

The panel took into account the NMC guidance on misconduct (FTP-2a last updated on 29 November 2021), which states:

> *"The Code sets the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that patients and public tell us they expect from nurses, midwives and nursing associates. While the values and principles can be interpreted for particular practice settings, they are not negotiable..."*

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code (2015). The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel was of the view that Ms Grant's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Grant 's actions amounted to a breach of the Code (2015). Specifically:

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

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

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

To achieve this, you must:

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

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

8 Work cooperatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

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

To achieve this, you must:

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

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

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

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

To achieve this, you must:

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

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

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public.

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

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

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

Charge 1b

The panel determined that flash meetings are crucial for addressing high-level risks in the Home. It is essential to communicate this information to both incoming shifts and managers. The panel determined that in failing to do so amounts to serious professional misconduct as these meetings provide valuable records that indicate which residents are at higher risk and require special attention. By documenting indicators or deteriorations, the flash meeting records help focus the attention of caregivers. The panel therefore determined that Ms Grant's failure in charge 1b does amount to serious professional misconduct.

Charge 1c

The panel determined that the minutes of meetings serve as evidence of disseminating crucial information regarding patient safety, policies, and procedures. As a manager, ensuring that staff members who cannot attend the meetings read the minutes is essential. It demonstrates commitment to sharing important information widely. Minuting staff meetings becomes particularly important when discussing new procedures and policies, as it allows the information to reach those who were not in attendance. The panel also observed that the onset of the pandemic in March 2020 further reinforced the need for staff to be knowledgeable about new pandemic-specific procedures, as well as being aware of the emerging issue of Covid-19 before the lockdown. The panel therefore

determined that Ms Grant's failure in charge 1c does amount to serious professional misconduct.

Charge 1h

The panel determined that care plans are essential tools that nurses use to provide appropriate and safe care to their patients. When care plans are incomplete or outdated, it poses a significant risk to patient safety. It is imperative to prioritise the regular updating of care plans to individualise patient care and address any potential safety risks. The panel therefore determined that Ms Grant's failure in charge 1h constitutes serious professional misconduct.

Charge 1j

The panel noted that handover documents play a vital role in providing essential information to nurses and caregivers regarding key aspects of patient care. The information contained in these documents ensures continuity of care and serves as a means to monitor patients effectively. However, insufficiently detailed handover documents can jeopardize patient safety and put them at risk of harm. Therefore, it is imperative that these documents contain comprehensive and accurate information. The panel therefore determined that Ms Grant's failure in charge 1j constitutes serious professional misconduct.

Charge 1k

The panel determined that the management of wound care is of utmost importance due to the potential rapid deterioration of patients' skin integrity. Regular measurement and monitoring of wounds are essential to promote healing and prevent complications. Neglecting this responsibility can lead to serious consequences, including injury, pain, discomfort, and infection for patients. The panel deemed the failure to undertake proper wound monitoring as a serious example of professional misconduct, given the potential harm it can cause to patients. The panel therefore determined that Ms Grant's failure in charge 1k constitutes to serious professional misconduct.

Charge 1l

The panel found that TMAR charts were not up to date. The panel noted that it is crucial to record the administration of all medications, including topical medications. This avoids the possibility of patients such as those with dementia or lacking in capacity receiving duplicate doses. This oversight can significantly interfere with their treatment plan. The panel determined that the failure to maintain up-to-date TMAR charts is a serious instance of professional misconduct. The panel therefore determined that Ms Grant's failure in charge 1l constitutes to serious professional misconduct.

Charge 1n

The panel determined that condition-specific care plans are essential documents that outline the specific care required for conditions such as diabetes. These plans consolidate and focus all the necessary care details for a service user into one comprehensive document. It is critical for the Home to implement such care plans, particularly for residents who are already at risk, as it minimises potential risks associated with their condition. Ms Grant's failure to implement condition-specific care plans for at-risk residents is serious professional misconduct. Without these plans, the overall risk for these patients increases, as their unique care needs may not be adequately addressed. Therefore, the panel has determined that this failure in charge 1n constitutes serious professional misconduct.

Charge 2a

The panel has concluded that the medication errors reported in this case constitute serious professional misconduct. The panel noted that these errors were only identified through an internal audit conducted sometime after the medication errors had occurred. The panel noted that timely and accurate administration of prescribed medications is vital for effectively managing the health conditions of the residents. The panel also noted the medication errors, particularly one involving a pain relief patch, had significant implications for the resident who could have endured pain due to the medication error. The panel therefore determined that this reinforces the needs to promptly investigate and address

any medication errors. In light of the identified failing in charge 2a, the panel determined that Ms Grant's actions amount to serious professional misconduct.

Charge 2b

The panel has determined that the inaccurate recording of medication errors amounts to serious professional misconduct. Accurate reporting of medication errors facilitates the identification of trends and ways to manage them, such as providing necessary training to individuals. The panel determined that such errors could put residents at risk. The panel therefore determined that Ms Grant's failure in charge 2b amounts to serious professional misconduct.

Charge 2c

The panel determined that repetition of medication errors impacts on patient safety. In the view of the panel Ms Grant's failure in charge 2c constitutes serious professional misconduct.

Charge 3

The panel acknowledges the challenging and stressful nature of the nursing profession. Clinical supervision plays a crucial role in providing nurses with an opportunity to discuss difficult cases, seek support, and address their training needs. It also helps in maintaining clinical competencies. Considering the importance of clinical supervision, the panel finds Ms Grant's failure in this regard to be serious professional misconduct.

Charge 4

The panel heard evidence from Colleague A who stated that Ms Grant made every effort to carry out her induction and although she felt that she had a comprehensive induction, it was not a 'full' induction as per company policy. However, taking Colleague A's evidence into account, who confirmed that the majority of the induction had been covered, the panel determined that the failure to conduct a full induction does not amount to serious misconduct.

Charge 6

The panel determined that Ms Grant's actions constitutes serious professional misconduct due to the failure to ensure a safe admission for a vulnerable resident who was receiving at end-of-life care. Considering the resident's numerous medical conditions and their vulnerability, this failure significantly increased the risk to the resident. The panel therefore determined that Ms Grant's failure in charge 6 constitutes serious professional misconduct.

Charge 7a

The panel heard evidence from Colleague A who said that Service User A was at end of life and that the monitoring the service user's weight would not be necessary given their prognosis. Taking this into account and using its own professional judgement, the panel determined that Ms Grant's actions did not constitute serious misconduct.

Charge 7b

The panel noted that Service User A was at end of life and suffered from medical conditions, including swallowing difficulties. The panel noted that there was only one month in April where the assessment was not undertaken. Having regard to the failure to assess this resident this increased the risk of appropriate care for that resident. The panel therefore determined that Ms Grant's failure in charge 7b constitutes to serious professional misconduct.

Charge 7c

The panel considered Witness 1's evidence who informed the panel that Service User A was "*continually crying out in pain*". The panel considered it imperative to monitor and record pain levels for the well-being of Service User A. By failing to meet this essential aspect of care, the panel determined that Ms Grant's failure in charge 7c constitutes to serious professional misconduct.

Charge 7d

The panel noted that MRSA, referenced as a superbug, poses a significant risk. The panel noted that Service User A was vulnerable and receiving end-of-life care. The panel determined that the failure to take appropriate action could potentially affect this service user, other service users, and staff in general if proper measures, such as barrier nursing, were not implemented. Therefore, the panel determined this failure amounted to serious professional misconduct.

Charge 7e

The panel noted that Service User A had been diagnosed with MRSA, and the failure to use necessary levels of PPE put this service user, other service users and staff at risk of cross-contamination. As a result, the panel determined that Ms Grant's failure in charge 7f amounts to serious professional misconduct.

Charge 7f

The panel determined that assessing the current condition of Service User A was necessary to determine any deterioration that might affect the risk to the individual and the level of care required. The failure to conduct the assessment by Ms Grant amounted to serious professional misconduct.

Charge 7g

The panel noted that moisture lesions can potentially lead to pressure ulcers, which is particularly concerning for a vulnerable resident such as Service User A. The panel also noted that skin tears can rapidly deteriorate. Adequate care can prevent these conditions from worsening, and failure to provide such care can cause additional discomfort and pain for the resident. Therefore, the panel concluded that Ms Grant's failure in charge 7g constitutes serious professional misconduct.

Charge 8

The panel determined that the failure to provide adequate safeguarding would put patients at risk. It would also not afford an opportunity to monitor trends in relation to safeguarding issues which would again impact upon patient or resident safety. The panel therefore determined that Ms Grant's failure in charge 8 constitutes to serious professional misconduct.

Charge 9

The panel determined that Ms Grant's failure in charge 9 constitutes serious professional misconduct. Although the panel acknowledges the uncertain and challenging circumstances faced during the Covid-19 pandemic and that policies and procedures were evolving to address the situation. The panel determined that the failure to implement the Home's infection policy would have impacted on all service users at a time when it would have been vital to ensure that infection levels were kept to an absolute minimum. The panel therefore determined that this charge constitutes serious professional misconduct.

The panel there found that Ms Grant's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct in charges 1b, 1h, 1j, 1k, 1l, 1n, 2a, 2b, 3, 6, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 8 and 9. The panel do not find that charges 1c and 4 amount to serious professional misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Grant's fitness to practise is currently impaired. The panel took into account the NMC guidance on 'impairment' (DMA-1, last updated on 27 March 2023).

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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d) …*

The panel considered that limbs a, b and c of Dame Janet Smith's test set out in the Fifth Report from Shipman were engaged by Ms Grant's past actions. The panel considered that Ms Grant's misconduct put vulnerable residents at serious risk of harm. The panel therefore considered that Ms Grant's failings in these respects brought the profession into disrepute. The panel was of the view that the provision of safe and effective care is a fundamental tenet of the profession, and Ms Grant breached such a tenet by her actions and omissions.

The panel went on to consider whether Ms Grant remained liable to place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel applied the test set out in the case of *Cohen* and assessed Ms Grant's levels of insight and remediation. The panel considered that the failings in this case were remediable.

The panel considered Ms Grant's evidence, including her reflections using the Gibbs model, training certificates, and a reference from her current employer dated 2 March 2021. The panel carefully considered the reflections and noted that Ms Grant's responses to the charges were at times misdirected and did not address the failings found proved. Additionally, the panel was of the view that Ms Grant attempted to shift blame onto others rather than taking full responsibility, indicating limited insight on her part.

Furthermore, the panel acknowledged that Ms Grant has been working as a bank nurse since 2021. However, there is no up to date evidence regarding her performance during this period or whether she has effectively addressed her failings. Consequently, the panel cannot be certain that she would not pose a potential risk to patients in the future, particularly in a managerial role.

The panel noted that although Ms Grant is apparently not currently in a managerial position, the charges found proved are still directly related to the responsibilities a nurse would typically have. These include maintaining updated care patient plans, ensuring thorough completion of handover documents, keeping wound care plans up to date, maintaining TMAR charts, and conducting service user admissions. The panel noted that these are fundamental nursing duties, and that there is no evidence that Ms Grant has addressed the concerns.

The panel was disadvantaged due to the absence of up to date references and testimonials regarding Ms Grant's performance. The panel only had sight to a reference from March 2021, which is outdated and does not reflect her current performance as a nurse. As a result, the panel concluded that her insight is limited, and there is little evidence of remediation. The panel therefore determined that there remains a risk of repetition and concluded 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 are 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, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of the profession. The panel considered that members of the public would expect registered nurses to be able to provide safe and effective care for vulnerable residents. The panel determined that a finding of impairment was necessary on public interest grounds, in order to maintain confidence in the nursing profession and in the NMC as a regulator, and in order to declare and uphold proper standards of conduct and performance.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of nine months. The effect of this order is that Ms Grant's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

Submissions on sanction

Mr Wigg invited the panel to impose a conditions of practice order, citing aggravating factors such as a consistent pattern of misconduct over a period of time that put patients at risk of suffering harm. He did, however, acknowledge mitigating factors, including the challenging and demanding nature of Ms Grant's position and that there is no evidence suggesting Ms Grant is currently undertaking a managerial position.

Mr Wigg submitted that a conditions of practice order is appropriate in this case to protect the public and satisfy the public interest. He submitted that the misconduct found can be addressed and there is no indication of underlying attitudinal issues. Mr Wigg submitted that a twelve-month period is deemed appropriate in this case. The restrictions imposed should primarily focus on addressing the managerial aspects, while also taking into consideration the clinical concerns in charges 6 and 7.

Decision and reasons on sanction

Having found Ms Grant's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the Sanctions Guidance (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:

- A pattern of misconduct over a significant period of time.
- Conduct which put patients at risk of suffering harm.
- Limited insight into failings.

The panel also took into account the following mitigating features:

- Some of the misconduct occurred during the course of the Covid-19 pandemic which was unprecedented.
- [PRIVATE].
- Ms Grant was working under the pressures of a demanding and prescriptive corporate structure during the Covid-19 pandemic.
- Misdirected support in place while Ms Grant was on annual leave [PRIVATE].
- For a period of six months, Ms Grant did not have the benefit of a deputy manager to support her. When she did have a deputy manager, that deputy manager was not fully inducted. Although the panel found the ultimate responsibility to induct the deputy manager lay on Ms Grant, there were other members of the managerial staff that were responsible for parts of that induction which had not been completed and therefore Ms Grant was disadvantaged by not having a fully inducted deputy manager.

- The panel considered the written evidence of Witness 5. In his evidence he conceded that Ms Grant herself did not have a full induction.
- The panel had some evidence that Ms Grant has been working as a bank nurse without further incident.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the misconduct. The panel decided that it would be neither proportionate nor in the public interest to take no further action, given the nature of the allegations and the extent of Ms Grant's failings. The panel therefore determined that taking no action was inappropriate in these circumstances.

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 Ms Grant's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Ms Grant's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence* (which was not capable of being addressed);

- No evidence to suggest that there was not a 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 there is no evidence of any deep-seated personality or attitudinal problems. However, the panel did identify areas within Ms Grant's practice that require supervision and retraining.

Although the panel determined issues relating to incompetence, it took into consideration the personal circumstances Ms Grant was subject to at the time. These included the added pressure caused by the Covid-19 pandemic, the unique culture of the home, and the nature of auditing while Ms Grant and the deputy manager were absent. Witness 4 provided oral evidence stating, "*Covid did have a massive impact; patients deteriorated during that time due to a lack of equipment*." The panel also noted that Ms Grant was not directly involved in hands-on care and that the issues arose from specific events related to governance and Covid-19, resulting in errors in documentation. It is likely that under normal circumstances, Ms Grant may not have made these errors. The panel therefore concluded that these issues can be supported through appropriate supervision and training.

The panel found no evidence to suggest that Ms Grant would not be receptive to retraining. It also determined that patients would not be directly or indirectly put in danger as a result of the conditions. Furthermore, the panel was satisfied that conditions would safeguard patients throughout their duration and could be effectively monitored. As a result, the panel concluded that it is feasible to establish suitable and practical conditions to address the shortcomings identified in this case.

The panel had regard to the fact that these incidents happened a considerable time ago and that, other than these incidents, Ms Grant had an unblemished career for a number of years as a nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, Ms Grant should be able to return to practise as a nurse. Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of Ms Grant's case. The panel has already identified that the misconduct is not fundamentally incompatible with Ms Grant remaining on the register and that conditions would address the misconduct found in this case.

Having regard to all of the above, the panel 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 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 will send the NMC a reference seven days in advance of the next NMC hearing or meeting from either:

   - your line manager, mentor or supervisor

   This reference must address your clinical practice and performance, specifically focusing on your ability to document clinical care and should you be in a managerial position, an assessment of your performance within that position.

2. Should you accept a managerial role during the course of your employment, you must have weekly supervision meetings with a band 6 nurse or above and this supervisor must provide any future panel with an overview of your progress, reflections and insight.

3. 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.

4. 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.

5. 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

6. 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.

7. 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 a period of nine months to allow Ms Grant the appropriate time to comply with the conditions.

Before the order expires, a panel will hold a review hearing to see how well Ms Grant has 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:

- Ms Grant's engagement at a future review hearing.
- Any evidence of training undertaken.
- Up to date references or testimonials from any work Ms Grant has undertaken, whether paid or unpaid.

Interim order

As the conditions of practice order cannot take effect until the end of the twenty-eight-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 Mr Grant's 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 Wigg. He invited the panel to impose an interim conditions of practice order for a period of eighteen months. This would be to ensure that an interim conditions of practice order remains in place in the event that Ms Grant lodges an appeal and remains in place until any such appeal has been determined.

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 eighteen months to allow for the possibility of 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 twenty eight days after Mr Grant is sent the decision of this hearing in writing.

That concludes this determination.

This will be confirmed to Ms Grant in writing.