Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

[Split Hearing]
9, 10, 13-17, 20-24, 27 and 28 November 2023
4-8, 11-15 and 18-20 December 2023

Virtual Hearing

Name of Registrant:	**Carol Anne Quinn**
NMC PIN	72D1217E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – August 1999 Learning Disabilities Nurse – August 1999
Relevant Location:	London Borough of Haringey
Type of case:	Misconduct
Panel members:	Paul O'Connor (Chair – Lay member) Alex Forsyth (Lay member) Sharon Peat (Registrant member)
Legal Assessor:	Suzanne Palmer Monica Daley from 4 December 2023 John Moir from 18 December 2023
Hearings Coordinator:	Vicky Green Elizabeth Fagbo on 13 December 2023
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Ms Quinn:	Not present and not represented in her absence
Facts proved:	Charges 1, 2, 3, 4, 6.a), 6.b), 6.c), 6.d), 7, 8.a), 8.b), 8.c), 8.d), 8.e), 8.f), 8.g), 9, 10.a), 10.b), 11.a), 11.b), 12, 13, 14, 16, 18.a), 18.b), 18.c), 19, 20, 21, 22.a), 22.b), 22.c), 23.a), 23.b)i., 23.b)ii., 23.c)i., 23.c)ii., 23.d), 23.e) 23.f), 23.g), 23.h), 24.a), 24.b), 24.c), 25, 26.a). 26.b)

Facts not proved:	Charges 5.a), 5.b),15 and 17
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Quinn was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 11 October 2023.

Mr Kennedy, 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 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 Quinn'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 Quinn had been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Quinn

The panel next considered whether it should proceed in the absence of Ms Quinn. It had regard to Rule 21 and heard the submissions of Mr Kennedy who invited the panel to continue in the absence of Ms Quinn.

Mr Kennedy drew the panel's attention to the proceeding in absence bundle which contained an email from the Royal College of Nursing(RCN) to the NMC dated 18 October 2023 in which the following was stated:

'Ms Quinn has advised me that she will not be attending the hearing. As per RCN policy I will be withdrawing representation for the hearing'

Mr Kennedy submitted that an adjournment would serve no useful purpose as Ms Quinn had voluntarily absented herself. He submitted that it was in the interests of justice to proceed in the absence of Ms Quinn.

The panel has decided to proceed in the absence of Ms Quinn. In reaching this decision, the panel has considered the submissions of Mr Kennedy, the email from the RCN and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones (Anthony William) (No.2) [2002] UKHL 5* 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 Quinn.
- Ms Quinn has informed the RCN that she will not be attending the hearing.
- There is no reason to suppose that adjourning would secure her attendance in the future.
- Six witnesses have made themselves available to give evidence at this hearing.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.
- The charges relate to events that occurred in 2019.
- 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.

The panel accepted that although the NMC had not heard directly from Ms Quinn regarding her decision not to attend, it was satisfied that the RCN acted on her behalf, and that the RCN's email of 18 October 2023 provided evidence of the decision made by Ms Quinn.

There is some disadvantage to Ms Quinn in proceeding in her absence. Ms Quinn will not be able to challenge the evidence relied upon by the NMC and she 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 Quinn's decision to absent herself from the hearing, waive her right 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 Quinn. The panel will draw no adverse inference from Ms Quinn's absence in its findings of fact.

Details of charge

That you a Registered Nurse, while Home Manager of The Highgate Care Home:

1. Did not ensure that policies and procedures were communicated and/or distributed to staff. **[Proved]**

2. Did not ensure medication protocols were adequate and/or in place. **[Proved]**

3. Did not ensure safe medication management systems were in place. **[Proved]**

4. Did not ensure the Resident's charts were being used and/or completed. **[Proved]**

5. With regards residents' care plans:

a) Did not ensure the necessary paperwork had been ordered. **[Not proved]**

b) Did not ensure they were updated and/or in place for all residents. **[Not proved]**

6. Did not ensure that where necessary, risk assessments were:

a) In place. **[Proved]**

b) Complete. **[Proved]**

c) Reviewed. **[Proved]**

d) Consistently followed by staff. **[Proved]**

7. Did not ensure 'Resident of the Day' reviews were carried out monthly for every resident. **[Proved]**

8. Did not take steps to ensure the security and/or safety of the residents in that:

a) Treatment rooms were not locked when not in use. **[Proved]**

b) Sluice rooms were not locked when not in use. **[Proved]**

c) Fire exits were not clear. **[Proved]**

d) Waste management sheets were not in place. **[Proved]**

e) There were no working pagers in the Home. **[Proved]**
f) Oxygen cylinders were being stored in clinical rooms and not outside. **[Proved]**
g) You did not ensure the Call Bell System was functioning in that there were no working pagers in the Home. **[Proved]**

9. Did not ensure the requirements of the Mental Capacity Act 2005 was being complied with in that the forms for capacity and/or best interest decisions were not filled in correctly. **[Proved]**

10. Did not ensure the DOLS tracker was:
a) Up-to date; and/or **[Proved]**
b) Accurate. **[Proved]**

11. Did not ensure that DOLS assessments were
    a) Completed competently; and/or **[Proved]**
    b) up to date. **[Proved]**

12. Did not ensure the DATIX system was being used properly or at all. **[Proved]**

13. Did not take action to replace Resident A's broken humidifier. **[Proved]**

14. Did not take adequate steps to ensure compliance with data protection law/regulations. **[Proved]**

15. Did not ensure 12 months of evidence within the Operational Essentials folders. **[Not proved]**

16. Did not ensure the Key Worker System was in place. **[Proved]**

17. Did not take action to promote communal activities for the Residents. **[Not proved]**

18. Did not ensure the Hazard Analysis Critical Control Points documentation was

a) Complete; and/or **[Proved]**
b) Correct; and/or **[Proved]**
c) Signed off. **[Proved]**

19. Did not adequately action safeguarding issues where SOVA applied. **[Proved]**

20. Did not ensure that what was reported on the Datix and the SOVA Operational Essentials tracker matched. **[Proved]**

21. Did not demonstrate that you took concerns raised to you seriously. **[Proved]**

22. In relation to Patient V did not:
a) Ensure that their challenging behaviour was documented. **[Proved]**
b) Ensure evidence of nursing need was recorded. **[Proved]**
c) Take steps to ensure the appropriate information was recorded so support their funding. **[Proved]**

23. In relation to Patient C:
a) A wound which had been present since 2013 was being dressed with Inadine which is inappropriate for long term use. **[Proved]**
b) The use of Inadine:
   i. Was not documented on their medication chart. **[Proved]**
   ii. Had not been prescribed. **[Proved]**
c) In the wound assessment chart there was
   i. No documented evidence **[Proved]**
   ii. No measurement of the wound **[Proved]**
d) No wound management care plan in place. **[Proved]**
e) No photographic evidence of the wound in the patient's notes. **[Proved]**
f) No evidence of the wound being reviewed by a relevant professional. **[Proved]**
g) No evidence that a referral to a Tissue Viability Nurse had been made. **[Proved]**
h) Did not make a timely referral to Speech and Language when he reported coughing when eating. **[Proved]**

24. In relation to Patient W:

a) Did not respond adequately to concerns raised by Nurse A and Patient W's niece that Patient W was scared of a male night nurse on 10 April 2018 in that **[Proved]**
b) No reassurance was given that you would look into the issue. **[Proved]**
c) Did nothing to investigate the concerns raised. **[Proved]**

25. Did not take steps to ensure the staff/multi-disciplinary team at the Home consistently provided a high standard of care to the residents. **[Proved]**

26. Did not effectively manage the clinical lead to ensure:

a) high quality good practice was delivered. **[Proved]**
b) satisfactory standards of care and practice were maintained. **[Proved]**

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

Decision and reasons on application to admit the witness statement of Ms 7

After hearing evidence from all of the NMC witnesses, Mr Kennedy made an application for the witness statement of Ms 7 to be admitted into evidence as hearsay. This application was made pursuant to Rule 31 of the Rules. Mr Kennedy referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*.

Mr Kennedy informed the panel that since providing the NMC with a witness statement, Ms 7 has passed away. He drew the panel's attention to a Trace Report that confirmed that Ms 7 had died.

Mr Kennedy submitted that the evidence contained in Ms 7's witness statement is relevant to the charges. He also submitted that the evidence of Ms 7 is not the sole or decisive evidence in this case. Mr Kennedy submitted that Ms Quinn has decided to not take part in the hearing and not responded to the charges meaningfully. He submitted that there is no reason for Ms 7 to have fabricated her witness statement, she had no prior dealings with the care home or either registrant before making her findings during a visit carried out as part of her role as a Risk and Governance inspector at BUPA.

Mr Kennedy submitted that Ms 7's evidence is supported by other witness evidence. He submitted that the charges are serious, both individually and cumulatively and may have an adverse impact on Ms Quinn's registration if found proved. Mr Kennedy submitted that there is a good reason for Ms 7's non-attendance. He submitted that prior to this hearing, Ms Quinn was informed that the NMC was going to make this application. Mr Kennedy submitted that taking all of the above into account, there would be no unfairness if the witness statement of Ms 7 was admitted into evidence as hearsay.

The panel accepted the advice of the legal assessor.

In reaching this decision, the panel had regard to Mr Kennedy's submissions, Rule 31 of the Rules, the principles set out in the case of *Thorneycroft* and the NMC Guidance on the admissibility of evidence as hearsay (Reference DMA-6 Last updated 01/07/2022).

The panel determined that the witness statement of Ms 7 is relevant to the charges, but it was not the sole or decisive evidence. In these circumstances, it is not possible for Ms 7 to attend the hearing. The panel was of the view that there was no reason for Ms 7 to fabricate her evidence. The panel noted that Ms Quinn was put on notice of this application and did not object to it. Having regard to all of the above, the panel decided to allow the witness statement of Ms 7 into evidence as hearsay. What weight to be attached to it will be determined in the panel's consideration of all of the evidence at a later stage.

Background

The charges arose whilst Ms Quinn was employed as the Manager of Highgate Care Home (the Home). The Home is a residential home that provides care to residents who have complex needs and a high level of dependency. As the Home Manager, Ms Quinn had overall responsibility for the health and well-being of all of the residents.

On 22 January 2019, BUPA Quality Manager (Ms 1) and Regional Director (Ms 2) visited the Home to undertake a Monthly Home Review. During this visit, concerns about medication management and clinical governance were raised by external professionals. Following these concerns being raised, BUPA provided extra support to the Home. When BUPA began looking into concerns, it is alleged that previous concerns that were raised by external professionals and by Ms 3 had not been reported to BUPA by Ms Quinn. If concerns are raised by an external stakeholder, these should be reported to the Regional Director at BUPA by the Home manager.

Ms 1 and Ms 2 put plans in place to improve the Home's performance and to address the concerns, however, it is alleged that these plans were not implemented. An internal investigation was carried out by BUPA and Ms Quinn was referred to the NMC. This referral was received by the NMC on 15 January 2020.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kennedy.

The panel has drawn no adverse inference from the non-attendance of Ms Quinn.

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:

- Ms 1: Regional Quality Manager at BUPA.
- Ms 2: Regional Director at BUPA.
- Ms 3: Employed by the Whittington Health & Islington Council People Directorate Nurse Lead for Clinical Standards, Quality and Assurance.
- Ms 4: Head of Operation Quality at BUPA.
- Ms 5: Employed by Islington Council as a Trusted Assessor Nurse.
- Ms 6: Nurse Assessor at Continuing Healthcare.

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.

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

Charge 1

1. Did not ensure that policies and procedures were communicated and/or distributed to staff.

This charge is proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 1, Ms 3 and Ms 7.

The panel had sight Ms 1's witness statement in which she stated the following:

> *'It is management's responsibility to ensure the policies and procedures are in place.'*

The panel accepted Ms 1's evidence in respect of this and determined that as the Home Manager, Ms Quinn had a duty to ensure that policies and procedures were communicated and/or distributed to staff.

The panel also noted the following contained in Ms 1's witness statement:

> *'The Registrant did on one occasion ask me to show her how to do something on the computer. Whilst helping, I noticed that she had over 5000 unread emails in her inbox. Most of our communications from BUPA came via email, given that so many were unread, the Registrant could not have been effectively keeping up to date with policy, paperwork, processes and other external emails.*
>
> *In addition, nurses did not have access to emails in the workplace which meant that they were unable to keep up to date with policy and paperwork themselves. They would have had to rely on verbal feedback from the Registrant and [Colleague A] but they were clearly not up to date themselves. This was easily*

resolved by myself and the Administrator in early 2019 and should have been done by Registrant or [Colleague A]…

.. Management was emailed new policies and paperwork by BUPA. It was their job to communicate these changes and policies to staff, this was not being done. As a result in the lack of communication, new paperwork, My Portrait, key safety risks, resident of the day, and resident specific plans such as for seizures and falls were not in place, or inadequate.

In this situation, I feel it would be unfair to blame the staff at the Home for the daily failings. The Registrant should have been identifying these issues and arranging training and help. I found that many of the issues were easily resolvable when BUPA went in after the suspension. Staff were receptive to training and sorting care plans. Under the Registrant's management, staff were not following BUPA policy as they were unaware that most policies existed. Examples include wound care, skin integrity, diet, metal capacity, Datix and care planning to name a few. The correct process and procedures were not in place for staff to follow. Staff can only follow what they know and only use the tools they have available to them. The staff were not capable because they were not being managed, they were oblivious to the correct procedures.'

The panel also heard oral evidence from Ms 1 and found her evidence to be consistent, credible and reliable in respect of this charge. It heard evidence from Ms 3 and Ms 7 that corroborated Ms 1's evidence. Having regard to all of the above, the panel found that Ms Quinn did not ensure that policies and procedures were communicated and/or distributed to staff. Accordingly, the panel found this charge proved.

Charge 2

2. Did not ensure medication protocols were adequate and/or in place.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 4 and Ms 5.
The panel had sight of Ms 1's witness statement and noted the following:

> *'I found that the front sheets on MAR charts (which detail key risks such as allergies and choking risks as well as specifying how to administer certain medications) were different on each floor of the Home.*
>
> *I found that TMARs (Topical Medication Administration Recording forms) were present in charts but the actual forms being used were out of date. The staff at the Home were unaware that these forms had been updated over a year ago. Some residents didn't have TMARs at all. The purpose of these records is to ensure clarity so that staff know what the topical medication is intended to treat, when and how often it should be given. A lot of this information was missing from TMARs such as the patient's name, DOB, name of cream, how often it was to be applied, what the cream was for and where it was to be applied. The registered nurses should have been reviewing and initialling these folders everyday. The Registrant and [Colleague A] had a duty to oversee what was happening on the floor, by also spot checking these folders.'*

The panel had sight of Ms 5's witness statement to the NMC in which she stated the following:

> *'MAR charts were not fully completed and lacked key information such as allergies, GP information and identifying information such as residents' date of birth. This information was missing for a number of residents.*
>
> *In addition, MAR charts were not properly completed by staff. There are codes on the bottom of the chart that staff can use to fill in the chart. Code C on a chart means "see more information overleaf". Staff at the Home were noting Code C on MAR charts but were then not providing further information overleaf. As a result, no explanation was being given as to what happened/what the issue was.*

Prescriptions attached to charts were out of date. A copy of each resident's prescription should be attached to their MAR chart. This provides staff with key information such as the prescribed dose of medication and prescribed route. Prescriptions are renewed every month. Despite prescriptions being renewed, old prescriptions were attached to MAR charts.'

The panel also heard oral evidence from Ms 1 and Ms 5. The panel found the evidence of Ms 1 and Ms 5 to be consistent, credible and reliable in respect of this charge. As the Manager of the Home, the panel determined that it was Ms Quinn's responsibility to ensure that medication protocols were adequate and/or in place. Having regard to all of the above, the panel found that Ms Quinn did not ensure that medication protocols were adequate and/or in place. The panel therefore found this charge proved.

Charge 3

3. Did not ensure safe medication management systems were in place.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It gave particular regard to the evidence of Ms 1, Ms 2 and Ms 7.

The panel had sight of Ms 1's witness statement in which she stated the following:

'Whilst on my walk around, I looked at various residents' charts. These should include information regarding food and fluid charts, a mattress check sheet, Topical Medication Administration Records ("TMAR"), medication charts and daily notes to name a few. The charts I checked often lacked information or were not filled in as necessary. I do not recall which residents these charts belonged to.'

The panel also had sight of Ms 2's witness statement, in particular the following:

'It was very difficult to audit the folders as the contents for the previous year were archived, and during the MHR you would review the previous month. I could only base the audit on any forms in the folder that had been completed in the current month. During the January MHR exhibited at EP/01a, I was unable to review many of the documents for December, some examples of what I found are listed below:

k) Concerns in relation to medication management- medication essentials treatment diary not being used.'

The panel had regard to the witness statement of Ms 7 in which the following was stated:

'Concerns in relation to medication management- medication essentials treatment diary not being used.

Medication PRN Protocols for "as required" medication and also topical medication were not always in place for some residents to support staff in administration.

…Controlled medications were not consistently checked weekly as per policy and medication essentials (which is a guide for staff in relation to the safe management of medication) was not always updated and used effectively.

I also found that clinical rooms and cleaning cupboards were unlocked, these should have been locked and secure as they contain medication and hazardous chemicals. This should have been picked up in walk around by management.'

The panel also heard oral evidence from Ms 1 and Ms 2. It found their oral evidence to be consistent with their documentary evidence and it was corroborated by the witness statement of Ms 7. As set out previously, the panel determined that Ms Quinn was under a duty to ensure safe medication management systems were in place. The panel

found that Ms Quinn did not ensure that safe medication systems were in place. Accordingly, the panel found this charge proved.

Charge 4

4. Did not ensure the Resident's charts were being used and/or completed.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 1.

The panel had regard to the witness statement of Ms 6 in which the following was stated:

> *'I had asked the registrant to improve documentation and to complete behaviour charts following an assessment I completed on 26 February 2016. The family disputed the information being documented in the patients notes. I asked that this be improve so that the behaviour and the level of care required could be documented efficiently going forward. This was not done when I reviewed the documentation at later visits. As a result, I had no evidence that would allow me to recommend that full funding should continue therefore I had to restart the funding process again be fully reassessed'.*

The panel had sight of Ms 6's witness statement and oral evidence in which she stated that Ms Quinn did not ensure that the Resident's charts were being used and/or completed. The panel found the evidence of Ms 6 to be consistent, credible and reliable in respect of this charge. The panel therefore found this charge proved.

Charge 5.a)

5. With regards residents' care plans:

a) Did not ensure the necessary paperwork had been ordered.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1.

The panel had sight of Ms 1's witness statement and noted the following:

'a) The paperwork needed to produce care plans had not even been ordered.'

The panel carefully considered the evidence of Ms 1, it noted that as there was no evidence presented of the systems in use for the ordering of paperwork, it could not be satisfied on a balance of probabilities that this charge was made out. The NMC failed to produce sufficient evidence to support the charge. The panel therefore found this charge not proved.

Charge 5.b)

5. With regards residents' care plans:
b) Did not ensure they were updated and/or in place for all residents.

The panel concluded that an unknown number of residents did have care plans in place and therefore charge 5 b) is not proved.

This charge is found not proved.

Charge 6

6. Did not ensure that where necessary, risk assessments were:
a) In place.
b) Complete.
c) Reviewed
d) Consistently followed by staff.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 2 and Ms 5.

The panel had sight of Ms 1's witness statement and Exhibit CQ 01, dated 22 January 2019 in which she stated the following:

> *'When a resident's weight changes, their moving and handling plans should be reviewed and adapted as needed, this was not being undertaken.*
> *One resident was on pureed food as a result of swallowing difficulty but no SALT (Speech and Language Therapist) consultation had been arranged.*
>
> - *No smoking risk assessment seen in safety plan*
> - *Bed rails no measurements, not counter signed*
> - *BI for lap belt and bed rails BI for lap belt is not fully completed…bed rails no measurements and no monthly r-v for Dec and Jan*
>
> *For residents with a high fall risk, there were no additional care plans in place to show how safety is managed. This is required for medium-high risk residents.'*

In her oral evidence, Ms 1 stated that despite having a duty to, Ms Quinn did not ensure that risk assessments were in place, complete, reviewed and consistently followed by staff.

The panel noted that Ms 5, in her witness statement, stated the following:

> *'I noticed that a few resident at the Home were in bed, with bed rails, but no bed bumpers were in place. The risk assessments for these residents stated that bumpers were in place. The Home therefore was not complying with their risk assessments and the residents were at risk of entrapment and injury.'*

'Bed rails and bumpers were now in place but risk assessments needed updating. Risk assessments need to be reviewed on a monthly basis and/or when there is a change. They were out of date.'

The panel also had sight of a contemporaneous record of concerns about risk assessments made by Ms 5 dated 1 March 2019. Ms 5 gave oral evidence and her evidence was consistent, credible and reliable.

Having regard to all of the above, the panel determined that Ms Quinn did have a duty to ensure that where necessary, risk assessments were in place, complete, reviewed and consistently followed by staff. This however did not happen. The panel therefore found this charge proved in its entirety.

Charge 7

7. Did not ensure 'Resident of the Day' reviews were carried out monthly for every resident.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 2 and Ms 7.

The panel had regard to the witness statement of Ms 1 in which she stated the following:

'This is a monthly review system for each resident in the Home, this is a clinical governance requirement within BUPA. I found that the Home was only carrying out one review per day in the whole Home, i.e. 30 or 31 reviews per month. As there were 52 residents at the time, some plans were not reviewed being reviewed on a monthly basis.

Monthly reviews should be carried out and should detail what has happened in that month e.g. any specialist visits (dietician, SALT), details of weight fluctuation, eating patterns etc. The purpose of this exercise is for staff to plan, review and evaluate care as per NMC standards (platform 3 assessing needs and planning care).

Management was emailed new policies and paperwork by BUPA. It was their job to communicate these changes and policies to staff, this was not being done. As a result in the lack of communication, new paperwork, My Portrait, key safety risks, resident of the day, and resident specific plans such as for seizures and falls were not in place, or inadequate.'

The panel had sight of an email from Ms 2 to Ms 4 dated 19 May 2019 in which the following was stated:

'Resident of the day not being carried out and overdue evaluations not being picked up the following day during HM / [Colleague A] walkabout when these should have been reviewed.'

The panel also heard oral evidence from Ms 1 and Ms 2 which was consistent with their written statements. The panel found the evidence of Ms 1 and Ms 2 to be credible and reliable in respect of this charge. The panel determined that Ms Quinn did have a responsibility to ensure that 'Resident of the Day' reviews were carried out for every resident each month. This however did not happen. The panel therefore found this charge proved.

Charge 8.a)

8. Did not take steps to ensure the security and/or safety of the residents in that:
a) Treatment rooms were not locked when not in use.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 2.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'On my walk round I found that treatment rooms containing medication were unlocked, these should be kept locked when no one is in there.'*

Ms 1 also recorded this in her notes dated 22 January 2019.

The panel also had sight of Ms 2's witness statement in which she stated the following:

> *'The clinical treatment rooms should also be locked, these were unlocked and wide open.'*

The panel heard oral evidence from Ms 1 and Ms 2 who confirmed that Ms Quinn had a duty to ensure that treatment rooms were kept locked when not in use to maintain the security and/or safety of the residents. It also heard from these witnesses that they found treatment rooms unlocked when they were not in use. The panel found the evidence of Ms 1 and Ms 2 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 8.b)

8. Did not take steps to ensure the security and/or safety of the residents in that:
b) Sluice rooms were not locked when not in use.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1.

The panel had sight of Ms 1's witness statement in which she stated the following:

'The sluice rooms at the Home should always be locked, these were unlocked and wide open.'

The panel also had sight of Ms 2's witness statement and noted the following:

'Sluice rooms were also open, this is where dirty laundry is stored, bed pans are washed and where waste is disposed. Sluice rooms are considered dirty should not be easily accessible to avoid cross-infection.'

The panel heard oral evidence from Ms 1 and Ms 2 who confirmed that Ms Quinn had a duty to ensure the security and/or safety of the residents. It also heard from these witnesses that they found sluice rooms unlocked. The panel found the evidence of Ms 1 and Ms 2 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 8.c)

8. Did not take steps to ensure the security and/or safety of the residents in that:
c) Fire exits were not clear.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 2.

The panel had sight of Ms 1's witness statement in which she stated that there *'was also items in front of fire exit'* in her walk round at the Home.

The panel also had sight of Ms 2's witness statement in which she stated that *'Fire exits were blocked and propped open.'*

The panel heard oral evidence from Ms 1 and Ms 2 who confirmed that Ms Quinn had a duty to ensure the security and/or safety of the residents. It also heard from these

witnesses that they found that fire exits were not clear. The panel found the evidence of Ms 1 and Ms 2 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 8.d)

8. Did not take steps to ensure the security and/or safety of the residents in that:
d) Waste management sheets were not in place.

This charge is found proved.

In reaching this decision, the panel took into account al of the evidence before it. It had particular regard to the evidence of Ms 1.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'There were no waste management sheets in place contrary to BUPA policy and NICE guidelines.'*

The panel also heard oral evidence from Ms 1 in which she stated that it was Ms Quinn's responsibility to ensure the security/and or safety of the residents. She also stated that waste management sheets were not in place at the Home. The panel found Ms 1's evidence to be consistent, credible and reliable in respect of this charge. The panel therefore found that it was more likely than not that Ms Quinn did not take steps to ensure the security and/or safety of the residents in that she did not ensure that waste management sheets were in place. Accordingly, the panel found this charge proved.

Charge 8.e)

8. Did not take steps to ensure the security and/or safety of the residents in that:
e) There were no working pagers in the Home.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 5.

The panel had sight of Ms 2's witness statement in which she stated the following:

> *'Pagers and Call Bell System- Staff are supposed to carry pagers on them during their shift. Residents can ring a call bell when in need and staff are notified through the pager. I found that there were no working pagers in the Home. I had offered more pagers to all the homes under my supervision. The Registrant said that it would be nice to have them as the Home had none that were working. They had 25 previously but these had all gone missing and were never replaced. The fact that this system was not in place meant that residents did not have a mechanism to call staff when needed, which raises concerns as to the safety of residents. I do not recall exactly when this came to my attention.'*

The panel also had sight of an email from Ms 5 sent to Ms 4 on 19 May 2019 in which she stated the following:

> *'Pagers for the call-bell system The home had no working pagers in the home. This was identified when I informed all of my Home Manager's there was a small supply of pagers available if any homes needed additional handsets. Carol responded that it would be nice to have pagers. The home had been running for a long time with none. Carol confirmed they used to have them in the home. The maintenance operative confirmed they used to have around 25 in the home but these had gone missing over a period of time and had never been replaced.'*

In her oral evidence, Ms 5 told the panel that Ms Quinn had a duty to ensure the security and/or safety of the residents. It also heard from Ms 5 that they found that there were no working pagers in the Home. The panel found the evidence of Ms 5 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 8.f)

8. Did not take steps to ensure the security and/or safety of the residents in that:
f) Oxygen cylinders were being stored in clinical rooms and not outside.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 5.

The panel had sight of the witness statement of Ms 5 in which she stated the following:

> *'Oxygen cylinders were being stored in clinical rooms. These should not be kept inside if they are not in use as they are a fire hazard. I escalated this concern to BUPA and had no further involvement with this.'*

The panel also had sight of Ms 5's notes from her visit to the Home dated 1 March 2019 in which the following was stated:

> *'It was identified that on the clinical room were stored the Oxygen cylinders – unsure of what the policy is, as it is normally advised to keep this equipment outside unless in use.'*

The panel heard oral evidence from Ms 5 who said that Ms Quinn had a duty to ensure the security and/or safety of the residents. It also heard from Ms 5 that they found that oxygen cylinders were being stored in clinical rooms. The panel found the evidence of Ms 5 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 8.g)

8. Did not take steps to ensure the security and/or safety of the residents in that:
g) You did not ensure the Call Bell System was functioning in that there were no

working pagers in the Home.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence as set out in charge 8.e). The panel therefore found this charge proved for the same reasons set out above at charge 8.e).

Charge 9

9. Did not ensure the requirements of the Mental Capacity Act 2005 was being complied with in that the forms for capacity and/or best interest decisions were not filled in correctly.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 3 and Ms 7.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'Completing mental capacity assessments and making best interest decisions for those who do not have capacity is a legal requirement under the Mental Health Act 2005. Within the Home, the forms for capacity and best interest decisions were not being filled in correctly; they were not person centred and not specific as to the Key Decision that had been made. Forms also lacked detail to evidence why this decision was made in the resident's Best interest.'*

The panel noted Ms 3's witness statement, in particular, the following:

> *'I informed BUPA of some of the concerns that [Ms 5] had reported, particularly concerns in relation to staff understanding and competency…*

… c. It was also unclear whether capacity assessments were in place for some residents.'

The panel had regard to Ms 7's witness statement in which she stated the following:

'Documentation relating to mental capacity was also not always compliant, it was not always clear how residents were supported to make their own decisions and personal preferences recorded.'

The panel also had sight of the BUPA Consent, Mental Capacity Act (MCA) 2005, Best Interest (BI) Decision Making and Depravation of Liberty Safeguards (DoLS) Policy dated 23 January 2019.

The panel also heard oral evidence from Ms 1 and Ms 3. It found their evidence to be consistent, credible and reliable in respect of this charge. The panel also found that the evidence of Ms 1 and Ms 3 was corroborated by the witness statement of Ms 7. Having regard to all of the evidence, the panel was satisfied that Ms Quinn had a duty to ensure the requirements of the Mental Capacity Act 2005 was being complied with in that the forms for capacity and/or best interest decisions were filled in correctly. This however had not happened. Accordingly, the panel found this charge proved.

Charge 10.a)

10. Did not ensure the DOLS tracker was:
a) Up-to date; and/or
b) Accurate

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 1 and Ms 4.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'In addition, the DOLS tracker in the Home was not up to date and accurate. It was not clear which residents were funded and by which authority. Some DOLS referrals had been sent to the wrong DOLS team. There were 17 safeguarding concerns raised in relation to DOLS from the initial inspection in January 2019.'*

The panel also had sight of Ms 4's witness statement in which she stated the following:

> 'DOLS- BUPA's "Consent, Mental Capacity Act (MCA) 2005, Best Interest (BI) Decision Making and Deprivation of Liberty Safeguard (DOLS) Policy" is exhibited at SH/09.
>
> a. DOLS are separate to the Datix system and therefore are not logged on this system.
> b. DOLS are managed by the Home and the respective DOLS authority. The Home deals with various DOLS authorities, these will differ depending on the residents referring authority.
> c. For DOLS to apply, a resident must meet the DOLS specific criteria and the Home must make an application. There were a high number of residents who met the criteria in the Home.
> d. It became apparent in the internal investigation that the Registrant was not following the correct DOLS procedure. She was sending all DOLS through to Islington via post, this was not always the correct place to be sending them as the Home was dealing with multiple DOLS authorities. When DOLS were not acknowledged or put in place due to them having been sent to the wrong location, the Registrant was not following up. The Registrant did not seem to understand that there were various DOLS authorities.
> e. In addition, paper applications were still being completed as opposed to using the streamlined online process.
> f. DOLS should appear on the Home's tracker, but the tracker was not being completed.'

The panel heard oral evidence from Ms 1 and Ms 4 who said that Ms Quinn had a duty to ensure that the DOLS tracker was up-to date and accurate. This however had not happened. The panel found the evidence of Ms 1 and Ms 4 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved on the balance of probabilities.

Charge 11

11. Did not ensure that DOLS assessments were
a) Completed competently; and/or
b) up to date.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2.

The panel had sight of the witness statement of Ms 2 in which she stated the following:

> *'During my visits to the Home, I had concerns about various processes that had lapsed and were detrimental to resident care. In particular:-*
>
> *f. Deprivation Of Liberty Safeguards ("DOLS") - I also identified in January that there were a number of residents who had received deprivation of liberty assessments and had DOLS in place which had lapsed. There was no evidence to suggest that these had been renewed. Anyone who is deprived of liberty has to have an assessment in place with conditions to ensure practices are not too restrictive. In February it was identified that 10 residents were unlawfully deprived of their liberty due to the fact that assessments were not in date, this went up to around 17 at a later date.'*

The panel also had sight of the BUPA Consent, Mental Capacity Act (MCA) 2005, Best interest (BI) decision Making and Deprivation of Liberty Safeguards (DOLS) Policy dated 23 January 2019.

The panel heard oral evidence from Ms 2, she informed the panel that Ms Quinn had a duty to ensure that DOLS assessments were completed accurately, received by the correct authority and followed up in a timely manner. This however had not happened. The panel found the evidence of Ms 2 to be consistent, credible and reliable. The panel therefore found this charge proved.

Charge 12

12. Did not ensure the DATIX system was being used properly or at all.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 4 and Ms 7.

The panel had sight of the witness statement of Ms 1 in which she stated the following:

> *'In particular, I found that there was a lack of understanding by staff of the Datix system. During my previous visit, I had specifically told staff to report appropriate issues on Datix, this was still not being done. I do not recall specific examples but I knew that that Datix was not being completed as I would pick up on medication issues and could see that they had not been recorded…*
>
> *… The Registrant was not very proficient with technology. She did not seek help in relation to this and simply did not carry out online tasks that she found difficult. An example of this is Datix, the Registrant's understanding of the system was not great. I supported and showed her how to report on Datix, she clearly did not find this easy.'*

The panel had sight of Ms 4's witness statement in which she stated the following:

> *'According to Datix, there was not a single medication incident in the Home between 2017 and 2018. Given the various reports I received during the internal investigation, this seems very unlikely. The MHR, completed 22nd January 2019 by [Ms 2] and [Ms 1], identified that since December 2018 there had only been 1 incident reported since December 7th 2018. It also noted that no medication incidents were reported in 2018 despite in medication audits gaps noted on meds charts was a consistent theme. Gaps on medication charts should be recorded as an incident. Thus it is much more likely that these incidents were not reported.*
>
> *From what was reported to me, my findings were that staff were not using the paper reporting forms, they were verbally reporting to the Registrant and [Colleague A] instead. This was a cause for concern as often a few shifts may have lapsed before the staff member saw the Registrants to report the issue. It also meant there was no paper trail.'*

The panel also had sight of Ms 7's personal notes that she completed after visiting the Home in which she has recorded the following:

> *'Staff don't complete DATIX forms – staff currently tell [Colleague A] and she completes.'*

The panel heard oral evidence from Ms 1 and Ms 4. In their evidence they told the panel that it was Ms Quinn's responsibility to ensure that the DATIX system was being used. This however did not happen. The panel found the evidence of Ms 1 and Ms 4 to be consistent, credible and reliable. It also found that Ms 7's evidence corroborated the evidence of Ms 1 and Ms 4. The panel found that Ms Quinn was responsible for ensuring that the DATIX system was being used properly. This however did not happen. The panel therefore found this charge proved.

Charge 13

13. Did not take action to replace Resident A's broken humidifier.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 4.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'There were instances where the Registrant was very slow acting in relation to issues that required immediate action. A resident's humidifier had broken and needed replacing, the humidifier was a vital part of the resident's care as a result of a tracheotomy (her throat had to remain moist). This was broken for three weeks before it was replaced. The Regional Director and I purchased a new humidifier but resident was without this for around three weeks.'*

The panel also had oral evidence from Ms 1 who stated that it was Ms Quinn's responsibility to replace Resident A's humidifier and she did not. The panel found Ms 1's evidence to be consistent, reliable and credible in respect of this charge. The panel was satisfied that it was Ms Quinn's responsibility to ensure that Resident A's broken humidifier was replaced as a matter of urgency. This however did not happen. Accordingly, the panel found this charge proved.

Charge 14

14. Did not take adequate steps to ensure compliance with data protection law/regulations.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2.

The panel noted the following in Ms 2's witness statement:

> *'…Cabinets designated to house confidential information were unlocked and I found that a variety of confidential paperwork had been left out at the nurse's stations and in the communal lounges with was a GDPR issue.*
>
> *Issues in relation to personal documentation been left unattended in the Home had not been rectified and therefore was still a GDPR breach. Medication treatment rooms, sluices and confidential cupboards were still unlocked and open…'*

The panel also heard oral evidence from Ms 2 who told the panel that Ms Quinn was responsible for ensuring that the Home was compliant with data protection law/regulations.

The panel found the evidence of Ms 2 to be consistent, credible and reliable. It found that Ms Quinn had a responsibility to ensure that the Home complied with data protection law/Regulations. This however did not happen. The panel therefore found this charge proved.

Charge 15

15. Did not ensure 12 months of evidence within the Operational Essentials folders.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the BUPA Quality Assurance Handbook (V2.3 10/18).

The panel noted the following in the BUPA Quality Assurance Handbook:

'Please note that Operational Essentials documentation should be retained for 4 years from date of creation in line with the Bupa Care Services document retention schedule. A minimum of 6 months worth of records must be kept on site at all times for use in the event of an internal or external inspection.'

Having regard to the above, the panel found that there was no duty on Ms Quinn to ensure that there was 12 months of evidence within the Operational Essentials Folder as the requirement was for six months of evidence. The panel therefore found this charge not proved.

Charge 16

16. Did not ensure the Key Worker System was in place.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2 and Ms 4.

The panel had sight of an email from Ms 2's to Ms 4 dated 19 May 2019 in which she stated the following:

'Key worker system: There was no key worker system in place, although there had been years previously. When [Mr 9] Regional Support Manager and myself had a resident meeting last week, resident's were delighted to hear about the key worker system and talked about poor communication in the home where they are asking for things but no-one was taking responsibility, causing frustration and residents not receiving desired outcomes.'

The panel also had sight of Ms 2's witness statement in which she stated the following:

'Key Worker System- This is a system in which residents are allocated a particular staff members as a point of contact for any issues/communication. The

system ensures that staff know the residents and their families well and that they have a designated point of contact that they are all aware of. I found that this system was not in place. It had been previously but this had lapsed. When we reintroduced this, the residents were delighted to hear this was coming back. I identified this issue in the January/February MHR.'

The panel had regard to the BUPA Investigation Summary created by Ms 4 dated 3 June 2019 in which the following was stated:

'Key worker system: There was no key worker system in place,'

The panel also heard oral evidence from Ms 2 and Ms 4 who confirmed that it was Ms Quinn's responsibility to ensure that the Key Worker System was in place. The panel found the evidence of Ms 2 and Ms 4 to be consistent, reliable and credible in respect of this charge. The panel therefore found that as the Home Manager Ms Quinn had a responsibility to ensure that there was a key worker system in place. This however did not happen. Accordingly, the panel found this charge proved.

Charge 17

17. Did not take action to promote communal activities for the Residents.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2.

The panel had sight of Ms 2's witness statement in which she stated the following:

'Activities and Communal Areas- I became concerned at the number of residents that were staying in their rooms 24/7. Residents used to come out of their rooms but this had stopped for most with no plausible reason. Activities such as the Music Man had also stopped, this is a visiting entertainer who used to hold small

group activities. BUPA restarted this enabling 25 out of 43 residents to come out of their rooms. No one could say why the residents were being kept inside their bedrooms and not encouraged to come out of their rooms. I identified this issue in the February.'

The panel also had sight of an email from Ms 2 to Ms 4 dated 19 May 2019 in which she stated the following:

'Residents staying in their rooms that used to come out of the room and very limited stimulation or social inclusion for residents in their rooms.'

The panel heard oral evidence from Ms 2 who said that it was Ms Quinn's responsibility to promote communal activities for the Residents. The panel however found that whilst communal activities were lacking, the NMC had not discharged its burden to prove that Ms Quinn had not taken steps to promote such activities. The panel therefore found this charge not proved.

Charge 18

18) Did not ensure the Hazard Analysis Critical Control Points documentation was
a) Complete; and/or
b) Correct; and/or
c) Signed off.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2.

The panel had sight of Ms 2's witness statement in which she stated the following:

'Environmental Health-As previously mentioned, I was informed in January that the Home had received a 2 star rating from Environmental Health. The Registrant informed me that the Home was expecting another visit from Environmental Health. The Registrant had assured me that everything was in place in anticipation for the visit. I arranged for an internal spot check visit to be carried out by the BUPA Hotel Services Department, and unfortunately the findings were of concern. In particular the HACCP (hazard analysis critical control points) documentation was incomplete, incorrect and had not been signed off. Kitchen cleanliness and organisation was not up to standard. Out of date food was found and there were mistakes made in relation to food storage and preparation. The HACCP policy which should have been presented upon inspection was not available. This was concerning as the Home's chef is expected to work to this policy but had not had sight of it. When Environmental Health did inspect the Home, they raised the rating from 2 star to 4 star. This would not have been the case had issues not been rectified as a result of the internal visit.'

The panel also had sight of Ms 4's BUPA Investigations Report dated 3 June 2019 in which the following was stated:

'HACCP documentation is still not being fully completed with cleaning tasks being missed or tasks being completed for pieces of equipment that you don't have, and the forms not being signed off…

… Chef Manager not ever read HACCP manual and lack of ownership knowledge in maintain standards.'

The panel also heard oral evidence from Ms 2 and Ms 4. In their evidence they told the panel that Ms Quinn was responsible for ensuring that the Hazard Analysis Critical Control Points documentation was complete, correct and signed off. This however, did not take place. The panel found Ms 2 and Ms 4's evidence to be consistent, credible and reliable in respect of this charge. The panel therefore found this charge proved.

Charge 19

19. Did not adequately action safeguarding issues where SOVA applied.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2 and Ms 4.

The panel had sight of Ms 2's witness statement in which she stated the following:

> *'In April 2019, I became aware that the Registrant and [Colleague A] had attended four external safeguarding meetings. The Registrant and [Colleague A] had fed back to me that no action points were set in the meetings. I contacted the Islington Safeguarding Team as I was concerned at the fact no actions had been set. [Mr 8] had chaired two out of four safeguarding meetings. He informed me that there were in fact actions and outcomes set, and that these could not have been made clearer to the Registrant and [Colleague A] in the meetings but I do not recall meeting with the Registrant about this. My correspondence with [Mr 8] can be seen at EP/06. I understand that the Chair of one of the other meetings was content with the action that the Home planned to take and, therefore, the Registrant was correct that no action points were set at that meeting.'*

The panel also had sight of the email Ms 2 sent to Mr 8 in April 2019.

The panel had regard to the witness statement of Ms 4 in which she stated the following:

> *'SOVA was not being followed by the Registrant, including not raising referrals with the safeguarding authority when necessary. One example was reported to me by the Registrant; a resident missed their medication as it had not yet arrived from the pharmacy. This was reported to me by [Ms 1] QM, I have no further details. This should have been investigated and raised as a safeguarding but*

was not.'

The panel also heard oral evidence from Ms 2 and Ms 4 who stated that Ms Quinn had a responsibility to ensure that she actioned the safeguarding issues where SOVA applied. However, this did not happen. The panel found the evidence of Ms 2 and Ms 4 to be consistent, credible and reliable. The panel therefore found that Ms Quinn was responsible for actioning safeguarding issues where SOVA applied. As this however had not happened, the panel found this charge proved.

Charge 20

20. Did not ensure that what was reported on the Datix and the SOVA Operational Essentials tracker matched.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 4.

The panel had sight of Ms 4's witness statement in which she stated the following:

'When I reviewed the tracker in the Home, it appeared that some safeguarding issues were present but these had not been logged on Datix. An example of this was a concern raised by the Tissue Vitality Nurse in relation to wound management in the Home. The Continuing Healthcare (CHC) nurse reported on February 28th 2019 a safeguarding concern as she visited a resident who had a sarcoma wound on his leg which was being dressed with inadine. There was no care plan in place, dressing changes not being recorded and no wound measurements. This was not logged on Datix. I cannot find any further information regarding this resident…

… . Safeguarding Of Vulnerable Adults ("SOVA")
This system applies to residents over the age of eighteen who live in care or lack capacity. BUPA has a legal and professional duty to report safeguarding issues

to external safeguarding teams where SOVA applies. There are various different categories which need to be reported: physical abuse, sexual abuse, financial abuse, organisational abuse, neglect, acts or omissions of modern slavery and domestic violence.

SOVA was not being followed by the Registrant, including not raising referrals with the safeguarding authority when necessary. One example was reported to me by the Registrant; a resident missed their medication as it had not yet arrived from the pharmacy. This was reported to me by [Ms 1], I have no further details. This should have been investigated and raised as a safeguarding but was not.'

The panel also heard oral evidence from Ms 4 who stated that it was Ms Quinn's responsibility to ensure that what was being reported on the DATIX and the SOVA Operational Essentials tracker matched. This however did not happen. The panel found the evidence of Ms 4 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 21

21. Did not demonstrate that you took concerns raised to you seriously.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 3 and Ms 6.

The panel had sight of Ms 1's witness statement in which she stated the following:

'The Registrant was generally uninterested in any suggestions for improvement and did not follow up on action points or feedback from my visits. I do not recall specifics but remember that most points brought to her attention were not acted on. Although it was the [Colleague A] who was responsible for carrying out the action plans, the Registrant, as the manager, should have ensured action.

In my meetings with the Registrant, she did not appear receptive to change and did not engage with attempts to improve the Home. She was often angry and did not believe our comments. In addition, I found that the Registrant was not approachable to residents, family members or any professionals who entered the Home, I witnessed how the Registrant spoke to these individuals and did not think she was approachable. She appeared to be always on the offensive and accused me of lying when reporting concerns.'

The panel had sight of Ms 3's witness statement in which she stated the following:

'I was in regular communication with the Registrant as a result of my role. I found that the Registrant was often reluctant to engage with services and accept support from external individuals such as myself. I therefore made an effort to form a good working relationship with the Registrant to encourage engagement.'

In her oral evidence, Ms 3 told the panel that Ms Quinn often dismissed concerns.

The panel had sight on Ms 6's witness statement in which she stated the following:

'The Registrant would become irritated with me when I would express my concerns and had a "here we go again".

Both the Registrant and the [Colleague A] did not like that I was raising concerns.

The Registrant and [Colleague A] did not positively respond to recommendations and requests made by me in relation to documentation and referrals. I made recommendations, such as the behaviour charts mentioned above, in an attempt to improve the quality and efficiently of their recording. These recommendations were not carried out.'

The panel had sight of Ms 2's witness statement in which she stated the following:

'Action plans- Throughout my visits, my feedback was not taken on board as the Registrant believed that she knew better. The action points that I set the home during the MHRs were not completed.'

The panel heard oral evidence from Ms 1, Ms 2, Ms 3 and Ms 6, all of whom found that Ms Quinn did not demonstrate that she took concerns raised to her seriously. The panel found the witnesses to be consistent, credible and reliable. The panel therefore found that Ms Quinn did not take concerns raised to her seriously. Accordingly, the panel found this charge proved.

Charge 22

22. In relation to Patient V did not:

a) Ensure that their challenging behaviour was documented.
b) Ensure evidence of nursing need was recorded.
c) Take steps to ensure the appropriate information was recorded to support their funding.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 6.

The panel had sight of Ms 6's witness statement in which she stated the following:

'The Home had reported that [Patient V] had challenging behaviour and as a result, they were experiencing increased difficulty when administering care. The challenging behaviour was described as punching, kicking and swearing at staff when personal care was being administered. This meant that administering personal care to [Patient V] took longer than expected and that often, more than two carers were required to carry out personal care. The Home said that the challenging behaviour was happening daily. This had been verbally reported within the Home and to the relatives of [Patient V].

Despite these issues, [Patient V's] challenging behaviour was not documented. I read through every note for [Patient V] going back to the date of admission into the Home, nothing was ever recorded in relation to challenging behaviour by the Home. At the time [Patient V] was fully funded. From [Patient V's] notes, there was no evidence of nursing need or any evidence that enhanced care was required. [Patient V] was therefore no longer eligible for funding based on this.

I had asked the Registrant to improve documentation and to complete behaviour charts for [Patient V] following an assessment I completed on 26 February 2018. [Patient V's] family disputed the information being documented in the patients' notes, I asked that this be improved so that the behaviour and the level of care required could be documented efficiently going forward. This was not done when I reviewed the documentation at later visits. As a result, I had no evidence that would allow me to recommend that full funding should continue. [Patient V] therefore had to restart the funding process again and be fully re-assessed.'

In her oral evidence Ms 6 told the panel that Ms Quinn had a responsibility to ensure that Patient V's challenging behaviour was documented, that evidence of nursing need was recorded and to take steps to ensure the appropriate information was recorded to support their funding. This however did not happen. The panel found Ms 6's evidence to be consistent, credible and reliable. The panel therefore found that Ms Quinn, as the Home Manager, did have a duty to ensure Patient V's challenging behaviour was documented, to ensure evidence of nursing need was recorded and to take steps to ensure that the appropriate information was recorded to support their funding as this had not been implemented, the panel found this charge proved.

Charge 23

23. In relation to Patient C:

a) A wound which had been present since 2013 was being dressed with Inadine which is inappropriate for long term use.

b) The use of Inadine:
   i. Was not documented on their medication chart.
   ii. Had not been prescribed.

c) In the wound assessment chart there was
   i. No documented evidence
   ii. No measurement of the wound

d) No wound management care plan in place

e) No photographic evidence of the wound in the patient's notes.

f) No evidence of the wound being reviewed by a relevant professional.

g) No evidence that a referral to a Tissue Viability Nurse had been made.

h) Did not make a timely referral to Speech and Language when he reported coughing when eating.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 4 and Ms 6.

The panel had sight of Ms 6's witness statement in which she stated the following:

> *'Upon assessing, I became aware that [Patient C] was receiving treatment at the Home for a wound that had been present since 2013.*
> *The nurses at the Home were dressing the wound with whatever they wanted. They were using Inadine and Tegaderm Foam Adhesive Dressing to treat the wound. Inadine is not something that can be used long term. There was no documented evidence in the wound assessment chart and no measurement of*

the wound. There was no wound management care plan in place to treat the wound, no photographic evidence of the wound in the patient's notes and no evidence of the wound having ever been reviewed by a GP, Dermatology or a Tissue Vitality Nurse. A Tissue Vitality Nurse referral had not been made and therefore the Home had not received any guidance on how to treat the wound. I advised that the Home should request a review by his GP, Tissue Vitality Nurse and query a dermatology referral regarding care and management of the wound.

Upon finding the wound, a referral should have been made to a Tissue Vitality Nurse for guidance on the correct course of treatment. This was not done.

In addition, Inadine, the medication that was being used on was not documented on their medication chart and had not been prescribed.

[Patient C] had also made the Home aware that he had begun coughing when eating. Nothing was done about this. This change should have been documented and a referral to Speech and Language should have been made to assess whether treatment or diet needed adjusting. There was a risk of choking as the Patient ate by himself.'

The panel also had sight of Ms 4's witness statement in which she stated the following:

'An example of this was a concern raised by the Tissue Vitality Nurse in relation to wound management in the Home. The Continuing Healthcare (CHC) nurse reported on February 28th 2019 a safeguarding concern as she visited a resident who had a sarcoma wound on his leg which was being dressed with inadine. There was no care plan in place, dressing changes not being recorded and no wound measurements. This was not logged on Datix. I cannot find any further information regarding this resident.'

The panel heard oral evidence from Ms 4 and Ms 6 who stated that Ms Quinn was responsible for ensuring the correct wound care was provided to Patient C and it was also her responsibility to ensure a timely referral was made to SALT when he reported

coughing when he was eating. This however did not happen. Having regard to all of the above the panel found this charge proved in its entirety.

Charge 24

24. In relation to Patient W:

a) Did not respond adequately to concerns raised by Nurse A and Patient W's niece that Patient W was scared of a male night nurse on 10 April 2018 in that
b) No reassurance was given that you would look into the issue.
c) Did nothing to investigate the concerns raised.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 6.

The panel had sight of Ms 6's witness statement in which she stated the following:

> *'One major concern that I did have in relation to a staff member at the Home, and also the way in which the matter was dealt with, was in relation to [Patient W] I am not willing to disclose the name of this patient due to data protection.*
>
> *I saw [Patient W] on 10th April 2018. [Patient W] had dementia. Her niece had become concerned about the fact that [Patient W] was scared of a male night nurse, I do not recall his name. [Patient W] niece thought that this nurse may have been doing "something" to her aunt as she was scared every time the staff member came near. The specifics of what "something" was being done was never discussed with me. The niece was also concerned that [Patient W's] notes were also very poorly documented.*

I asked [Patient W's] niece if she was happy for me to report her concerns to management at the Home immediately. The niece was reluctant to report as "concerns were not taken seriously" at the Home.

I reported these concerns to the Registrant and [Colleague A], along with [Patient W's] niece, that day.

The response by the Registrant and deputy manager was not adequate. No reassurance was given to myself or the niece that they would look into the issue and ultimately nothing was done to investigate.

I found out that the niece had previously requested female carers, back in February 2016 when [Patient W] was admitted to Home, but this had not been done.

The Registrant and [Colleague A] said that [Patient W's] care plan would be changed to reflect this request.

I do not know whether a female nurse was assigned to the patient after this as her funding came to an end in May 2018 so I had no further dealings…

…It was the Registrant's responsibility to investigate and deal with this issue.'

The panel also heard oral evidence from Ms 6. The panel found that Ms 6's evidence in respect of this charge was consistent, credible and reliable. The panel was satisfied that Ms Quinn had a responsibility to respond adequately to concerns raised by Nurse A and Patient W's niece by investigating the issue and providing reassurance to the resident and their niece that matters would be resolved. This however did not happen. The panel found that there is a risk of abuse in a setting where patients are unable to speak up and express themselves. This was of particular concern in the Home given that it housed the most complex patients, of which around 95% did not have capacity. The panel therefore found this charge proved in its entirety.

Charge 25

25. Did not take steps to ensure the staff/multi-disciplinary team at the Home consistently provided a high standard of care to the residents.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 2, Ms 3 and Ms 4 and its earlier findings.

The panel had sight of Ms 2's witness statement in which she stated the following:

> *'As part of her role as manager of the Home, the Registrant was responsible for leading, supervising and directing a multi-disciplinary team to ensure that care was delivered to a consistently high standard to the residents of the Home in accordance BUPA values.'*

The panel bore in minds its findings so far in the charges set out above. The panel was of the view that Ms Quinn, as the Home manager was under a duty to ensure that the staff/multi-disciplinary team at the Home consistently provided a high standard to the residents. This however did not happen. This failure to ensure that the Home provided a high standard of care is encompassed by all of the charges that have been proved so far. The panel therefore found this charge proved.

Charge 26

26. Did not effectively manage the clinical lead to ensure:
a) high quality good practice was delivered.
b) satisfactory standards of care and practice were maintained.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it and it's previous findings in respect of the charges that have been found proved. The panel also had regard to the evidence of Ms 2.

The panel had sight of Ms 2's witness statement in which she stated the following:

> *'The Registrant was expected to professionally manage safeguarding issues and take the lead in developing and maintaining strong relationships with the local safeguarding teams.*
>
> *The Registrant was expected to manage the Clinical Lead within the Home, [Colleague A], to ensure that high quality good practice was delivered consistently and that satisfactory standards of care were maintained…*
>
> *…From my visits to the Home, the above expectations were not met by the Registrant.'*

The panel determined that Ms Quinn had a responsibility to effectively manage Colleague A. This however did not happen. The charges found proved so far demonstrate that high quality good practice was not delivered and satisfactory standards of care and practice were not maintained. The panel therefore found this charge 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 Quinn'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 ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

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

Mr Kennedy 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 Kennedy identified the specific, relevant standards where in his submission, Ms Quinn's actions and omissions amounted to misconduct. He submitted that Ms Quinn

was a highly experienced nurse in a position of authority and, as the manager of the Home, she had been entrusted to care for vulnerable residents. Mr Kennedy submitted that Ms Quinn, in her role as the care home manager was responsible for delivering consistently high standards of care which she failed to do. He submitted that Ms Quinn's communication during the time period in question was poor and she failed to take concerns seriously and act on them. Mr Kennedy submitted that Ms Quinn's actions and omissions fell below the standard expected of a registered nurse acting as a care home manager and amounted to misconduct.

Submissions on impairment

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

Mr Kennedy submitted that limbs a, b and c of the test set out in the case of *Grant* are engaged. He submitted that Ms Quinn's misconduct caused actual harm to Patient C and Patient W and posed a real risk of harm to other residents in her care. Mr Kennedy submitted that not giving medication in accordance with prescriptions, food not being prepared in accordance with care plans and staff competence not being checked properly all have the potential to cause serious harm to residents. He submitted that the public would be appalled at the fact that the manager of the Home did not take action and allowed poor practice to take place and continue.

Mr Kennedy submitted that Ms Quinn, although she has denied the charges, she has not made any further comment or provided any explanation. Mr Kennedy submitted that Ms Quinn has not provided any up to date references, testimonials or reflective statement to demonstrate insight into what went wrong and why.

Mr Kennedy submitted that as the misconduct is potentially remediable but there is no evidence of remediation. He submitted that whilst there is nothing to suggest that Ms Quinn had repeated the misconduct since the period in question four years ago, she is not currently working in a nursing role. Mr Kennedy submitted that Ms Quinn provided some positive testimonials, training certificates and a reflective statement. However, this evidence was provided some years ago and he submitted that Ms Quinn has not shown full insight into her failing and had not demonstrated that she has remediated her practice.

Mr Kennedy submitted that Ms Quinn's fitness to practise is currently impaired on public protection grounds. He submitted that the misconduct found presents a level of risk of harm to patients. Mr Kennedy submitted that as Ms Quinn has not demonstrated full insight or remediation there is a risk of repetition.

Mr Kennedy submitted that the public would expect a finding of impairment and would be appalled to learn that Ms Quinn behaved in such a lax manner, allowed patients to be placed at risk of harm and did not take third party concerns seriously and did nothing to address these concerns. Mr Kennedy submitted that a finding of impairment is necessary to protect the reputation of the profession and to uphold and maintain proper standards.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

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

'1 Treat people as individuals and uphold their dignity

1.2 *make sure you deliver the fundamentals of care effectively.*

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

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

2.6 *recognise when people are anxious or in distress and respond compassionately and politely.*

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.*

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

5 Respect people's right to privacy and confidentiality

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

6.2 *maintain the knowledge and skills you need for safe and effective practice.*

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.*

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

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

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

13.2 *make a timely referral to another practitioner when any action, care or treatment is required.*

13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence.*

14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.*

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

16.2 *raise your concerns immediately if you are being asked to practise beyond your role, experience and training.*

16.3 *tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can.*

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

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

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

18.4 *take all steps to keep medicines stored securely.*

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.*

20 Uphold the reputation of your profession at all times

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

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.*

25.2 *support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken.'*

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

However, the panel was of the view that as the manager of the Home, Ms Quinn had a duty to ensure that the fundamentals of care were delivered to all residents in her care and that staff were supported, competent and aware of policy and procedure and she failed in that duty. The panel found that there was no evidence that Ms Quinn had kept herself up to date with training and, as a consequence, she placed residents at a risk of harm. The panel determined that Ms Quinn's failure to work with third party

professionals and implement the recommended changes was serious and placed residents at risk of harm. The panel found that Ms Quinn's failure to act in accordance with the Mental Capacity Act (2005) and the resulting breaches of confidentiality were serious.

The panel was of the view that Ms Quinn's actions and omissions in delaying referring residents to the tissue viability nurse and SALT as well as delaying ordering a humidifier for a patient with a tracheostomy placed residents at a risk of harm and was serious. The panel was also of the view failing to work with multi-disciplinary teams to ensure that residents were provided with the correct care and treatment was serious.

The panel determined that Ms Quinn's failure to ensure that medication was safely stored and administered raised serious concerns about patient safety. The panel was of the view that the absence of risk assessments and inadequate completion of other risk assessments and failing to ensure that incidents were reported properly also raises serious patient safety concerns. The panel was also of the view that in not investigating allegations that a resident was scared of a nurse, Ms Quinn failed to put the needs of that resident first and placed the resident at a risk of harm.

Having regard to all of the above, the panel found that Ms Quinn's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

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

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 found limbs a, b and c engaged.

The panel found that Ms Quinn's misconduct caused actual harm to two residents and placed multiple residents at a risk of harm over a significant period of time. The residents in Ms Quinn's care were put at risk of harm through poor practice in failing to seek expert review and assessment from either the tissue viability nurse or SALT. By not ensuring medication was administered in accordance with prescriptions, the wrong amounts of thickener were being used which could lead to choking and aspiration and which risked fatal consequences. The panel also found that Ms Quinn's misconduct placed residents at risk of harm by not ensuring that staff were competent, aware of policies and procedures and reporting incidents.

The panel found that Ms Quinn's misconduct was serious and concluded that a fully informed member of the public or fellow nurse would be alarmed to hear about the inadequate care provided to the residents at the Home. The panel determined Ms Quinn's misconduct breached fundamental tenets of the profession and brought the reputation into disrepute.

The panel was of the view that the misconduct found, as primarily clinical in nature, is potentially remediable. However, the panel was mindful that when shortfalls were identified by third parties, Ms Quinn did not take the opportunity to remediate the concerns and to implement change. The panel was also mindful of its findings in respect of Ms Quinn not taking the concerns seriously and considered that the misconduct could potentially be attitudinal in nature and therefore more difficult to remediate.

The panel noted that Ms Quinn is currently employed at a care home but working in a role that does not require a nursing registration. The panel had sight of a bundle of

documents provided to the NMC by Ms Quinn in 2020. The bundle contained a number of positive testimonials, some evidence of training and a reflective statement. The panel found however, that Ms Quinn's reflective statement was limited and did not fully address the shortfalls in her practice. The panel had no current information about the steps Ms Quinn has taken to strengthen her practice or any information about her current level of insight.

Having regard to all of the above, the panel concluded that there is a risk of repetition of the misconduct and a consequent risk of harm. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel determined that a finding of impairment on public interest grounds is required as given the seriousness and nature of this case, public confidence in the profession would be undermined if a finding of impairment were not made. The panel therefore found Ms Quinn's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Quinn's fitness to practise is currently impaired on public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Ms Quinn off the register. The effect of this order is that the NMC register will show that Ms Quinn has been struck-off the register.

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

Submissions on sanction

Mr Kennedy informed the panel that the NMC sanction bid is that of a conditions of practice order or a suspension order. He set out some factors that are aggravating and mitigating in his submission. Mr Kennedy submitted that the matters found proved are serious, wide-ranging, they have not been remediated and Ms Quinn has not provided any evidence of full insight.

Mr Kennedy informed the panel that Ms Quinn made an application for Agreed Removal on the basis that she is currently working in a non-nursing role and has no intention of returning to nursing before she retires next year. He therefore submitted that in these circumstances, a conditions of practice order may not be workable. Mr Kennedy referred the panel to the SG and submitted that the choice of sanction to impose is ultimately a matter for the panel.

Decision and reasons on sanction

Having found Ms Quinn'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 SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The misconduct was serious, wide-ranging and related to fundamental nursing practice.
- The pattern of misconduct persisted months after concerns were raised.
- Ms Quinn failed to implement the recommended changes and actions agreed with external agencies and failed to preserve safety and act in the best interests of the residents.
- Ms Quinn's actions and omissions caused harm to two residents.
- A high number of extremely vulnerable residents with complex needs, some of whom lacked capacity, were put at risk of serious harm through Ms Quinn's actions and omissions.
- Ms Quinn has not demonstrated full insight or remorse into her misconduct.

The panel decided that there were no mitigating features of this case. It was of the view that Ms Quinn's long career as a registered nurse meant that she should have had the skills, knowledge and expertise to provide the best possible care to residents or to seek help when necessary.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Quinn's practice would not be appropriate. 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 Quinn's misconduct was far from being at the lower end of the spectrum and that a caution order

would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Quinn's registration would be a sufficient and appropriate response.

Whilst many of the concerns were clinical in nature, and as such could be expected to be remediated through retraining, given the lack of engagement and Ms Quinn's stated position that she has no desire to return to nursing, the panel determined that a conditions of practice order would be inappropriate in the particular circumstances of this case. Ms Quinn was the manager of the Home and had responsibility for ensuring the safety and wellbeing of the residents in her care. The panel found that even when a multitude of concerns about the Home and patient safety were raised, Ms Quinn did not take these seriously and allowed poor practice to continue, which caused actual harm to two residents and placed a number of very vulnerable residents at a risk of serious harm. The panel noted that although Ms Quinn has provided a reflective statement, some testimonials and training certificates in 2020, she has not provided any up to date information to suggest that she is willing to engage and to strengthen her practice.

The panel is therefore of the view that there are no practical or workable conditions that could be formulated for the reasons set out above. The panel concluded that the placing of conditions on Ms Quinn's registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel found that Ms Quinn's misconduct was not isolated. It occurred prior to concerns being raised in January 2019, and then persisted until she resigned from her post at the Home in April 2019 despite having the opportunity to address the concerns and implement change. This unwillingness to comply with recommendations from experienced and senior colleagues demonstrates and attitude that cannot be easily remedied. The panel has been provided with no evidence to suggest that Ms Quinn feels any remorse for her failings or that she now understands the impact they had on residents and their families, her colleagues, the nursing profession and the wider public confidence in that profession. Having found that Ms Quinn did not take the concerns seriously, the panel was of the view that her behaviour in knowingly continuing to place very vulnerable residents at a risk of harm was indicative of a deep-seated attitudinal problem.

Whilst there has been no repetition of the behaviour since the charges occurred, the panel noted that Ms Quinn has not worked as a registered nurse since she resigned from her post in April 2019. The panel noted that given that misconduct occurred after concerns were initially raised in January 2019, Ms Quinn repeated the misconduct at the time in question. Given Ms Quinn's lack of full insight and all of the above, the panel determined that there is a high risk of repetition of the misconduct and a consequent risk of harm to patients.

In the light of the above, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*

- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Ms Quinn, as the Home manager and registered nurse had a duty to ensure the wellbeing and safety of patients. The panel found that Ms Quinn demonstrated a disregard for the fundamental principles of nursing and she did not:

- Act with kindness.
- Prioritise people.
- Practise effectively.
- Promote professionalism and trust.

Ms Quinn's actions were serious departures from the standards expected of a registered nurse and are incompatible with her remaining on the register.

The panel was of the view that the findings in this particular case demonstrate that Ms Quinn's actions were serious and to allow her to continue practising would not protect patients and it would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Quinn's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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

Interim order

As the striking off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Quinn's own interests until the substantive sanction of a striking off order takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy who invited the panel to impose an interim suspension order for a period of 18 months. He submitted that if an appeal is made the substantive order will not come into force for that appeal period and the public would not be protected and the wider public interest would not be satisfied.

Mr Kennedy submitted than an interim suspension order would be appropriate in the circumstances. He submitted that if an appeal is made, this can often take a considerable amount of time to be heard by the High Court and therefore an 18 month interim suspension order is necessary to cover the appeal period. He submitted that if no appeal is made, then the substantive order will take effect at the end of the 28 day appeal period.

The panel accepted the advice of the legal assessor.

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. It was of the view that to not impose an interim order would be inconsistent with its previous findings.

The panel concluded that an interim conditions of practice order would not be appropriate, proportionate or workable for the reasons set out in it's determination on sanction. The panel decided to impose an interim suspension order to protect the public and meet the public interest considerations of this case, for a period of 18 months to cover the appeal period, should any appeal be made.

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

This will be confirmed to Ms Quinn in writing.

That concludes this determination.