Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

4 –13 & 15 – 19 & 21 – 28 March & 2 April & 8 – 12 April 2024 & 16 – 18 April 2024 & 20 – 22 May, 24 & 28 – 31 May 2024 & 10 – 20 June 2024 & 10 – 13 September 2024, 9 – 18 and 22 – 23 October 2024, 4 – 11 and 13 – 21 February 2025, 28 – 29 April 2025

Virtual Hearing

Name of registrant:	Kevin Michael Sidney Adams
NMC PIN:	10I0608E
Part(s) of the register:	Registered Nurse - Sub Part 1 Adult Nursing - July 2011
Relevant location:	Milton Keynes
Type of case:	Misconduct
Panel members:	Nicola Jackson (Chair, Lay member) Richard Curtin (Registrant member) David Newsham (Lay member)
Legal Assessor:	Alain Gogarty (4 – 13 & 15 – 19 & 21 – 28 March & 2 April & 8 – 12 & 16 – 18 April 2024 & 10 – 13 September 2024, 9 -19 and 22 – 23 October 2024 and 4 - 11 and 13 - 21 February 2025) Graeme Henderson (20 – 24 May 2024) John Bromley-Davenport (28 – 31 May and 10 - 20 June 2024) Alain Gogarty (4 – 11 & 13 – 21 February 2025 and 28 – 29 April 2025)
Hearings Coordinator:	Sherica Dosunmu (4 -13 & 15 - 19 & 21 – 28 March & 2 April & 8 - 12 April 2024 & 16 –18 April 2024 & 20 - 24 May & 28 - 31 May 2024) Anya Sharma (10 - 20 June 2024 & 10-13 September 2024, 9-18 and 22 - 23 October 2024 4 – 11 and 13 – 21 February 2025) Monsur Ali (28 – 29 April 2025)

Nursing and Midwifery Council:	Represented by Julian Norman, Case Presenter
Mr Adams:	Not present and unrepresented
Registrant B:	Present and represented by Tubo Uranta Not present but represented by Tubo Uranta on 4 & 18 March 2024 Present but unrepresented on 20 May 2024
Registrant C:	Not presented and unrepresented
Facts proved:	1a (in relation to subsection 6 of schedule A in relation to Resident B), 3 (in relation to subsections 7, 8, 10, 12, 15, 17, 19, 20, 21, 22, 37 and 38 on Schedule C), 4a (in relation to subsection 24 on Schedule D), 6, 17, 18b, 25, 26a, 26c, 27a, 27c, 28 and 29
Facts not proved:	1a (in relation to subsections of Schedule A 1,2,3,4,5,7,8,9,10,11,12,13,14 and 15), 1b, 2 (in its entirety), 3 (in relation to subsections 1,2,3,4,5,6,9,11,13,14,16,18,23,24,25,26,27,28, 29,30,31,32,33,34,35,36,39 and 40 of Schedule C), 4a (in relation to 1,2,3,4,5,6,7, 8, 9,10,11,12,13,14,15, 16,17,18,19,20,21,22,23, 25,26,27,28 and 29 of Schedule D), 4b, 5 (in its entirety), 7, 8, 9, 10, 11 (in its entirety), 12, 13, 14, 15 (in its entirety), 16 (in its entirety), 18a, 18c, 18d, 18e, 18f, 18g, 19, 20, 21, 22, 23, 24, 26b, 27b and 27d
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 Mr Adams was not in attendance and that the Notice of Hearing letter had been sent to Mr Adams' registered email address on 22 February 2024.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and means of joining the virtual hearing and, amongst other things, information about Mr Adams' right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Norman, 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.

In the light of all of the information available, the panel was satisfied that Mr Adams has 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 Mr Adams

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

Ms Norman informed the panel that the NMC attempted to communicate with Mr Adams on a number of occasions regarding this hearing, but there has been no response to emails or calls made by the NMC. She indicated that the NMC's secure file sharing software, Egress, has shown that Mr Adams has been accessing the emails sent to him by

the NMC, despite there being no response. She submitted that in light of his lack of engagement, there is no reason to believe that an adjournment would secure Mr Adams' attendance on some future occasion. She reminded the panel that there are a number of witnesses lined up to give evidence at this hearing who would be impacted by an adjournment. Further, she submitted that there is public interest in the expeditious disposal of this case.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Mr Adams;
- Mr Adams has not responded to various communications from the NMC in relation to this hearing;
- Mr Adams has been accessing secure emails sent by the NMC;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Five witnesses are due to give evidence, and may be caused inconvenience if there was a delay to this hearing;
- The charges relate to events that occurred in 2014/2015;
- Further delay may have an adverse effect on the ability of witnesses to accurately to recall events; and

- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Adams in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email address, he will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his 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 weaknesses or inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Adams' decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Adams. The panel will draw no adverse inference from Mr Adams' absence.

Details of charge (as amended)

That you, whilst employed as a Registered Nurse and/or Deputy Manager at the Five Acres Care Home:

1) Failed to ensure that an adequate standard of record keeping/ documentation was maintained in the home in relation to one or more residents:
    a) As set out in Schedule A;
    b) Generally.

2) Failed to ensure that Care Plans and/or Assessments in relation to one or more residents, were created or completed in a timely manner/ if at all:

    a) As set out in Schedule B.

3) Failed to ensure that Care Plans and/or Assessments were reviewed and/or updated on a regular basis in relation to one or more Residents and/ or ensure that such reviews were undertaken by staff at the home:

    a) As set out in Schedule C;
    b) Generally.

4) Failed to adequately document wounds, bruises and dietary needs appropriately or at all in relation to one or more Residents and/ or ensure that such documentation was undertaken by staff at the home:

    a) As set out in Schedule D;
    b) Generally.

5) Failed to make, or ensure that, necessary and/ or timely referrals in relation to one or more Residents were made:

    a) As set out in Schedule E;
    b) Generally.

6) On the 25th March 2015, did not inform the Tissue Viability Nurse, when asked, that Resident A had other pressure sore areas that were not intact.

7) Your action in charge 6 was dishonest in that you knew that Resident A had other pressure areas that were not intact and you did not disclose this to the Tissue Viability Nurse.

8) Did not provide/ensure that Resident A was provided with a relieving cushion for their chair on:

    a) 19th March 2015 and/ or

b) 25th March 2015

9) Following Resident B's skin integrity breaking down between April-June 2015, a pressure relieving mattress was not put in place until the 6th June 2015.

10) On or before the 28th April 2015, did not ensure that suitable wound dressing materials were available at the home.

11) Practised inadequate medication administration in that you:

a) Pre-potted medication for Residents within the home;
b) Failed to supervise student nurses during medication rounds;
c) Failed to wake Residents in order for medications to be administered.

12) Did not ensure that Resident C's Falls Risk Assessment was updated following a number of falls.

13) Between 1400h on 21/5/15 and 1400h on 22/5/15, following a fall by Resident C:

a) Failed to conduct/ ensure that observation checks were conducted at 30 minute intervals; and/ or

b) Did not record that/ ensure that any such checks were recorded.

14) Failed to provide or ensure that appropriate nursing care was provided to Resident D in that you did not take/ ensure that weekly blood sugar readings were taken.

15) Between 8/8/14 and 2/1/15, failed to provide or ensure that an adequate standard of care was provided to Resident F in that you did not:

a) Take/ ensure that the Waterlow Assessment was conducted on a monthly basis; and/ or

b) Did not record/ ensure that such assessments were recorded.

16) Failed to provide/ ensure that an adequate standard of nursing care was provided to Resident G in that no care plans and/ or risk assessments were in place in respect of the following:

a) Pressure ulcers;
b) Palliative care;
c) Aspiration Pneumonia;
d) Nutrition;
e) Dysphagia; and
f) CVA and contractures.

17) Performed a manual evacuation procedure on Resident F when it was not clinically justified or appropriate to do so.

18) Failed to ensure that Resident A received an adequate standard of care, in that you:

a) On the 20/3/15, did not reposition/ ensure that Resident A was repositioned every two hours between 1400h and 2100h.
b) On the 21/3/15, did not ensure that Resident A was repositioned every two hours;
c) On the 23/3/15, allowed the use of a faulty mattress in respect of Resident A;
d) On the 8/4/15, was not repositioned at all between 0720h and 2100h;
e) Did not ensure that Resident A's sacral wound dressing was changed every two days on or around the 13/5/15;
f) Did not ensure that Resident A was provided with the minimum of 1500mls of fluids on a daily basis.
g) Between the 1/3/15 and 11/6/15, did not ensure that Resident A was provided with the Ensure Plus supplements on a daily basis.

19) In or around May 2015, on more than one occasion, did not offer/ ensure that Resident A was offered an alternative breakfast following their refusal of the meal offered.

20) Between the 31/3/15 and 17/5/15, did not ensure that Resident A was woken from their sleep in order to eat their meals on more than one occasion.

21) Did not record whether alternative meals were offered to Resident A after waking from their sleep or ensure that such information was recorded.

22) Failed to ensure that food and fluid intake records were completed to an adequate standard in respect of one or more residents.

23) Did not ensure that Resident A's sacral ulcer dressing was changed on a regular basis.

24) Between 1st and 11th June 2015, you failed to:

a) Identify and/ or escalate Resident A's deterioration;
b) Recognise that Resident A's left leg had become gangrenous.

25) On the 27/8/14 you made/ sent an inappropriate comment, remark or words via message set out to the effect below:

Name	Message
KA	"Resident got broken down heel nearly open???? Bloody nurses here are shocking"
Colleague 1	"WHAT!!!"
KA	"Yep thankfully it's been spotted and should b ok"
Colleague 1	"Has it been kept in house or are we going to get

	a sova again, don't want another fore sore to heal"
KA	"In house but gotta lie"
Colleague 1	"Thanks for sorting it AGAIN mate"
KA	"Last Time!"

26) On the 2/9/14 you made/ sent an:

a) Inappropriate and/ or

b) Discriminatory and/ or

c) Offensive

Remark or words to the effect set out below:

Name	Message
KA	"The daughter said to me when she came to view her mum had lost loads of weight fuck knows how big she was before" "Expense fuck that Pran wont do it for one fat cunt"
KA	"That's not to say I wouldn't work anywhere else with you trouble shooting just no longer five acres it's the place and the workers all fucking self centered wankers."

27) On the 2/9/14 you made/ sent an:

a) Inappropriate and/ or

b) Discriminatory and/ or

c) Offensive and/ or

d) Racist remark or words to the effect set out below:

Name	Message
KA	“Surjeet is there tomorrow… but not but lol… great I’m keeping away or ill but him”
Colleague 1	“What up the arse!!”
KA	“Yeah”
Colleague 1	“ahahahah”
KA	“once you go black you won’t get your belongings back!!”

28) On the 21/10/14 you made/sent an:

a) Inappropriate and/ or

b) Discriminatory and/ or

c) Offensive and/ or

d) Racist remark or words to the effect set out below:

“Fat blackie said she phoned as was told that she wasn’t on the rota tonight by a carer.”

29) Between September 2014 and July 2015 you made/sent an:

a) Inappropriate and/ or

b) Discriminatory and/ or

c) Offensive and/ or

d) Racist remark or words, about a colleague or resident, on more than one occasion.

SCHEDULE A

	RESIDENT	EVENT
1.	A	Did not ensure that Resident A had a Repositioning Chart in place from the date of admission on the 16/3/15.
2.	A	Did not ensure that Repositioning Charts for Resident A between 24/3/15 and 5/4/15.

3.	A	Did not ensure that the type of mattress system in use by Resident A was recorded within the patient notes.
4.	A	Did not ensure that food intake charts for Resident A were kept between 16/3/15 and 28/3/15.
5.	B	Between 19th February 2015 and 9th June 2015, repositioning charts were not completed.
6.	B	Between June 2014 and January 2015, Resident B's Falls Care Plan was not reviewed on a monthly basis.
7.	B	Failed to ensure that Resident B's use of diazepam was monitored or if it was, did not ensure that the monitoring was recorded.
8.	C	Resident C's Mental Capacity Plan made no reference to their diagnosis of Vascular Dementia.
9.	C	Resident C's Fluid Intake Chart was not completed on a daily basis.
10.	D	Following an incident on the 10th May 2015, was not recorded and no incident report created.
11.	D	No behaviour care plan was implemented to mitigate against safety harms to take account of crawling behaviour.
12.	D	Resident D's Death and Dying Plan was not dated.
13.	H	On the 7th March 2015, Resident H's fluids chart had not been completed.
14.	H	On the 8th March 2015, Resident H's fluids chart had not been completed.
15.	H	A pain care plan was not implemented for Resident H until the 26th August 2015.

SCHEDULE B

	RESIDENT	EVENT
1.	A	A specific care plan for Resident A's sacral pressure sore was not created until the 19th April 2015, having been identified on the 16th March 2015.
2.	B	Did not ensure that an epileptic care plan and seizure protocols were devised in respect of Resident B.
3.	B	Failed to create a specific care plan in relation to Resident B's pressure areas.

4.	B	A personalised Falls Care Plan was not created in respect of Resident B.
5.	B	A Bed Rails Assessment was not carried out until January 2015.
6.	B	A Manual Handling Assessment was not completed in respect of Resident B until 1/11/14
7.	B	No Care Plan, Risk Assessment or Monitoring Charts were in place in relation to Resident B's epilepsy.
8.	F	A Wheelchair Risk Assessment not implemented until July 2015.
9.	F	No personalised seating plan was in place for Resident F.
10.	G	No care plans or preventative strategies were in place from March 2015 to mitigate Resident G's pressure ulcer development.
11.	G	No care plans or preventative strategies were in place for the management of the dry and fragile area of skin on Resident G's left heel identified on the 2nd February 2015.
12.	G	Redness to Resident G's buttocks was identified on the 6th March 2015. No care plan was developed until the 27th April 2015.
13.	H	A Behaviour Care Plan and Mental Capacity Care Plan in respect of Resident H were not developed until the 21st July 2015.
14.	H	A Personal Cleaning and Dressing Care Plan was not developed until the 23rd July 2015.
15.	H	No care plan was developed in respect of Resident H's right ankle pressure ulcer which was identified on the 26th December 2014.

SCHEDULE C

	RESIDENT	EVENT
1.	A	Did not evaluate Resident A's care plan after the 7th May 2015.
2.	A	Did not evaluate Resident A's Nutrition care plan after the 18th May 2015.

3.	A	Did not evaluate Resident A's Death/ Dying care plan during their time at the home.
4.	A	Did not evaluate Resident A's Hygiene care plan after the 6th May 2015.
5.	A	Did not evaluate Resident A's incontinence plan after the 7th May 2015.
6.	A	Did not evaluate Resident A's night sleeping care plan after 3rd May 2015.
7.	B	Did not review/ ensure that Resident B's care plan was regularly reviewed.
8.	B	Did not review Resident B's Falls Care Plan on a regular basis between June 2014 and January 2015.
9.	B	Did not ensure that Resident B's Waterlow Assessment and Pressure Risk were reviewed monthly between January 2015 and April 2015.
10.	B	Did not ensure that Resident B's Risk Assessment was regularly reviewed, despite Resident B having several falls/ between 10/4/14 and 11/1/15
11.	B	Resident B's risk assessment was not reviewed after March 2015.
12.	B	Resident B's moving and positioning care plan was not updated monthly to reflect their changing needs.
13.	B	Resident B's skin integrity plan was created in February 2014 but it was not reviewed/ updated until March 2015.
14.	B	Resident B's bowel assessment was not updated between June and November 2014.
15.	C	Resident C's mental capacity plan was not updated on a monthly basis.
16.	C	Resident C's falls risk assessment was not updated following a number of falls between March-May 2015.
17.	C	Resident C's diabetic care plan was not regularly updated.
18.	C	Resident C's waterlow assessment was not updated monthly between June 2014 and January 2015
19.	C	Resident C's hygiene plan was not updated between June 2014 and January 2015.
20.	C	Resident C's care plan for communication was not updated

		between June 2014 and January 2015.
21.	C	Resident C's continence plan was not updated between June 2014 and January 2015.
22.	C	Resident C's care plan for diabetes was not reviewed between June 2014 and 22nd January 2015.
23.	C	The Manual Handling Assessment was not reviewed regularly in 2015.
24.	D	Nutrition care plan was not regularly reviewed.
25.	D	Diabetic care plan was not updated before January 2015.
26.	D	Communications care plan was not regularly reviewed between October 2014 and January 2015.
27.	D	Behaviour Care Plan was not reviewed.
28.	D	Bed Rails assessment was not reviewed for three months following admission to the home.
29.	D	Resident D's falls care plan was not reviewed on a monthly basis in 2014 and 2015 as stipulated in October 2013.
30.	D	Resident D's Death and Dying Plan was not reviewed whilst at the home.
31.	G	Diabetic care plan and weekly blood sugar check was not regularly reviewed in 2015
32.	G	Resident G's BMI and MUST score was not updated after December 2014.
33.	G	Resident G's oral health assessment was not updated on a monthly basis.
34.	G	Resident G's bowel assessment was not updated on a monthly basis from October 2014.
35.	G	Resident G's falls assessment was not updated on a regular basis from the 15th October 2014
36.	G	Resident G's continence care plan was not regularly reviewed.
37.	G	Resident G's hygiene care plan was not reviewed on a regular basis from the 15th October 2014.
38.	G	Resident G's communication care plan was not reviewed on a regular basis from the 15th October 2014.
39.	G	Resident G's manual handling assessment was not updated in 2015.
40.	H	Resident H's mobility plan was not reviewed before May 2015.

SCHEDULE D

	RESIDENT	EVENT
1.	A	Failed to record the depth of sacral ulcer when completing a wound evaluation form on the 18th March 2015.
2.	A	Failed to record the depth of sacral ulcer when completing a

		wound evaluation form on the 23rd March 2015.
3.	A	Failed to mention sacral ulcer within a safeguarding alert.
4.	A	The “wound bed” section on a Wound Evaluation Chart dated 25/3/15 was crossed through/ incomplete even though Resident A had a Grade 2 pressure wound.
5.	A	On the 19th May 2015, after changing Resident A’s sacral ulcer dressing, did not record any further details on the condition of that ulcer.
6.	A	On the 1st June 2015, after changing Resident A’s sacral ulcer dressing, did not record any further details on the condition of that ulcer.
7.	A	Did not complete/ ensure that a body map was completed after the 16th March 2015.
8.	A	Entries documenting that Resident A had good fluid and diet intake whilst at the home were inaccurate.
9.	A	On the 28th April 2015, there were no records relating to pressure ulcers, body maps or skin inspections for Resident A.
10.	A	Body maps for Resident A were not completed on a weekly basis as advised by the TVN on the 1st May 2015.
11.	A	Resident A’s Temperature was not regularly monitored.
12.	A	Did not ensure that resident A’s MUST scores were recorded monthly whilst at the home Pg A695 Dr 1.
13.	A	Did not ensure that indication of food types or meal composition were consistently recorded in Resident A’s food intake charts.
14.	A	Did not ensure that food intake or refusals of food were consistently recorded in the food intake charts.
15.	A	There are no records of Resident A taking three full meals in any one day.
16.	A	On the 28/2/15 Resident A’s daily record shows that their food and fluid intake was good although there are no further records to indicate what food was taken and Resident A’s fluid chart shows as 300ml of intake for that day, which is inadequate. Pg A696 Dr 1
17.	B	In 2015, did not ensure that Resident B’s weight loss was reviewed.
18.	B	Between January and May 2015, did not update Resident B’s nutritional care plan on a monthly basis.
19.	B	In May 2015, the recommendations as provided by dietician/ SALT were updated in Resident B’s care plan but their significant weight loss was not documented.
20.	B	Patient records suggested that Resident B had a good appetite which was incorrect.

21.	B	Resident B's diet chart was not always completed between January and August 2015.
22.	B	Resident B was not always offered a pureed diet even though this is the recommendation given by SALT.
23.	B	Nutritional care plan was not personalised or adapted to meet the changing needs of Resident B.
24.	B	Between January and May 2015, Resident B's MUST score and weight monitoring was not completely on a monthly basis.
25.	B	Following Resident B's skin integrity breaking down between April and June 2015, a Respective Care plan was not implemented until September 2015.
26.	C	Resident C's nutritional care plan was not updated regularly.
27.	F	Resident F's nutritional plan was not personalised or regularly reviewed.
28.	F	Resident F's weight was not reviewed in March 2015
29.	H	No action plan was implemented following Resident H scoring a MUST score of 2 on the 3rd May 2015.

SCHEDULE E

	RESIDENT	EVENT
1.	A	A referral to the Tissue Viability Nurse in relation to Resident A's Grade 4 left heel pressure sore and Grade 2 sacral area pressure sore was not made until the 23rd March 2015, having been identified on the 16th March 2015.
2.	A	A referral to SOVA (safeguarding and vulnerable adults) referral in relation to Resident A's Grade 4 left heel pressure sore and Grade 2 sacral area pressure sore was not made until the 22nd March 2015, more than 24-48 hours after they were identified on the 16th March 2015.
3.	A	A referral to the Tissue Viability Nurse in relation to Resident A's grade 3 sacral ulcer on or around the 1st April 2015.
4.	A	A referral to the Tissue Viability Nurse in relation to resident A's deteriorating, grade 4 wound was not made until the 24th April 2015 (even though noted as deteriorating on 17/4/15.
5.	A	A referral to the Dietician as recommended by the TVN in May 2015.
6.	C	Referral to the Falls team before the 21st May 2015, Resident C having sustained falls on the 31st March, 6th, 16th, 26th

		April and 21st May 2015.
7.	H	Resident H was not referred to the GP or Dietician
8.	H	Following an assessment by the dietician on the 9th July 2015, Resident H was not referring to SALT for a swallow assessment until the 3rd September 2015.
9.	H	A referral to the Tissue Viability Nurse was not made following identification of Resident H's grade 2 pressure ulcer.

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

Decision and reasons on application to amend charges 27(d), 27(e), 27(f), 27(g)

On 12 March 2024, the panel heard an application made by Ms Norman to amend the letters in the sub-paragraphs of charge 27. The proposed amendments were to change the letters in the sub-paragraphs in charge 27 from '*d', 'e', 'f', 'g*' to *'a', 'b', 'c', 'd'*, in order to correct an apparent formatting error.

Ms Norman explained that the format of these charges appeared to have been altered by autocorrect in error. She submitted that the proposed change to the format was simply to provide clarity and to avoid confusion.

<u>Original charges:</u>

27) On the 2/9/14 you made/ sent an:

d) Inappropriate and/ or

e) Discriminatory and/ or

f) Offensive and/ or

g) Racist remark or words to the effect set out below:

Proposed charges:

27) On the 2/9/14 you made/ sent an:

a) Inappropriate and/ or

b) Discriminatory and/ or

c) Offensive and/ or

d) Racist remark or words to the effect set out below:

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such amendments would not change the nature of the charges and would only correct a formatting error. The panel was satisfied that there would be no prejudice to Mr Adams and no injustice would be caused to either party by the proposed amendments being allowed. It determined that it was therefore appropriate to allow the amendments to ensure clarity and accuracy.

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

On 22 March 2024, Ms Norman made a request that a part of this case be held in private. She indicated that she wished to refer to sensitive and personal issues relating to Witness 6 during the course of her proposed hearsay application to admit the statement of Witness 6 in evidence without formal proof. The application was made pursuant to Rule 19.

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

Having heard that there will be reference to sensitive personal matters concerning a third party, the panel determined to hold such parts of the hearing in private to protect the privacy of the third party involved.

Decision and reasons on application to admit hearsay evidence

Ms Norman made an application under Rule 31 to admit Witness 6's NMC written witness statement and local statement exhibit as hearsay evidence. She informed the panel that Witness 6 was no longer able to give live evidence in these proceedings.

Ms Norman submitted that strenuous attempts have been made by the NMC to contact Witness 6, but unfortunately, she has left the country. She informed the panel that Witness 6 is currently in Sudan [PRIVATE]. She explained that Witness 6 has also made it clear that she is not in a position to give live evidence in light of [PRIVATE].

Ms Norman submitted that by applying the principles of relevance and fairness referred to in Rule 31, Witness 6's written witness statement and exhibit should be admitted as hearsay evidence. She referred to cases *El Karout v NMC [2019] EWHC 28 (Admin),* and *Thorneycroft v NMC [2014] EWHC 1565 (Admin),* which sets out that there must be good and cogent reasons for the non-attendance of a witness. She submitted that there are compassionate circumstances involved with the non-attendance of Witness 6 and considering that she is currently dealing with [PRIVATE], it would be too much to expect her to give evidence in these proceedings.

Ms Norman explained that at the time of the concerns raised in this case, Witness 6 was a student nurse at Five Acres Care Home (the Home). She submitted that Witness 6 was able to address several issues raised in this case, such as; care planning, pre-potting of medication, supervision of students and the manual evacuation allegedly conducted by Mr Adams on a patient.

Ms Norman stated that Witness 6 made a contemporaneous local statement to Thames Valley Police, dated 12 May 2016, in addition to a later NMC statement. She submitted that in these circumstances it was relevant to admit Witness 6's NMC and local statements.

In relation to fairness, Ms Norman submitted that Witness 6's evidence was not the sole determinative evidence in respect of any of the issues addressed as there are other witnesses such as Witness 1 and Witness 5, who also address these matters. She submitted that the weight of Witness 6's evidence can be tested through the evidence of Witness 1 and Witness 5.

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

The panel approached its decision by considering firstly the relevance of the hearsay evidence and then secondly whether it would be fair to admit it having regard to the principles identified in the case of *Thorneycroft v NMC*.

The panel considered whether Witness 6's NMC written witness statement and contemporaneous local statement exhibit contained relevant evidence. The panel considered that Witness 6 was present at the Home at the time of the concerns raised and was able to address issues which relate to several charges, such as; care planning, pre-potting of medication, supervision of students and the manual evacuation allegedly conducted by Mr Adams on a patient. The panel was therefore of the view that Witness 6's statements would be relevant to the matters of this case.

The panel next considered whether it would be fair to admit this evidence. It noted that the NMC made attempts to secure the attendance of Witness 6, which were unsuccessful as she was currently in Sudan [PRIVATE]. The panel accepted this as a cogent reason for the non-attendance of Witness 6. The panel also took into account that the NMC has not been given any indication of when Witness 6 will be back from Sudan, and there was public interest in the issues of this case being explored fully, which supported the admission of this evidence into the proceedings.

The panel noted that Witness 6's written statements were not the sole or decisive evidence relied upon in respect of any of the charges in this case, and the weight of Witness 6's evidence is testable by cross reference to Witness 1 and Witness 5's live evidence. The panel therefore determined that it would be possible to fairly assess Witness 6's evidence.

The panel has made a careful assessment of the proposed hearsay evidence in accordance with the guidance set out at paragraph 45 of the decision in the case of *Thorneycroft v NMC*.

Additionally, the panel noted that there is no suggestion that Witness 6 had reason to fabricate the information provided in her statements.

In these circumstances, the panel was satisfied that this evidence was relevant and that it would not be unfair to Mr Adams if it were admitted. The panel will of course give appropriate weight to this evidence and will bear in mind that it will not be tested in cross examination.

The panel therefore decided to allow the NMC written witness statement and local statement of Witness 6 to be admitted as hearsay evidence.

Decision and reasons on application to amend Schedule C

On 11 April 2024, the panel heard an application made by Ms Norman to amend Schedule C in relation to Resident C and Resident F. She submitted that the proposed amendments would more accurately reflect the evidence.

The proposed amendments were to change the following:

<u>Original Schedule C:</u>

19.	*C*	*Resident C's hygiene plan was not updated between June 2014 and January 2015.*
20.	*C*	*Resident C's care plan for communication was not updated between June 2014 and January 2015.*
21.	*C*	*Resident C's continence plan was not updated between June 2014 and January 2015.*
22.	*C*	*Resident C's care plan for diabetes was not reviewed between June 2014 and 22nd January 2015.*
29.	D	Resident D's falls care plan was not reviewed on a monthly basis in 2014 and 2015 as stipulated in October 2013.

Proposed Schedule C:

19.	*C*	*Resident C's hygiene plan was not updated between March 2014 and January 2015.*
20.	*C*	*Resident C's care plan for communication was not updated between ~~June~~ **March** 2014 and January 2015.*
21.	*C*	*Resident C's continence plan was not updated between ~~June~~ **March** 2014 and January 2015.*
22.	*C*	*Resident C's care plan for diabetes was not reviewed between June ~~2014~~ **2013** and 22nd January 2015.*
29.	~~D~~ **F**	Resident D's falls care plan was not reviewed on a monthly basis in 2014 and 2015 as stipulated in October 2013.

In respect of the amended dates, Ms Norman submitted that these changes would not substantially change the charges faced by Mr Adams, as proposed changes incorporate periods already being considered. In respect of the proposed change from Resident D to Resident F, she submitted that this would correct what appeared to be the result of a typographical error.

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel noted that the proposed amendments to the dates within Schedule C, in relation to Resident C, extend the period being considered in the charges and does not cover a period already being considered. It noted that this also included a significant extension of the time period being considered, as the change from '*June 2014*' to '*June 2013*' would

backdate the time period being considered by a year. The panel was of the view that such changes would substantially change the nature of the charges faced by Mr Adams as it could affect the severity of the matters set out in Schedule C.

Further, the panel noted that an amendment from Resident D to Resident F would mean that Schedule C would refer to a matter that Mr Adams was not fully informed on and would not have had the opportunity to respond to.

Overall, the panel was of the view that the proposed amendments to Schedule C could cause potential prejudice and injustice to Mr Adams, as the nature of the Schedule would be different to matters Mr Adams would have been referred to. The panel therefore concluded that in these circumstances was not appropriate to allow the amendments. It rejected all proposed changes to Schedule C.

Adjournment

On 18 April 2024, the hearing adjourned during the evidence of Registrant B due to lack of time.

On 20 May 2024, the case was further adjourned due to issues with timetabling and transcript.

Case resuming on Wednesday 29 May 2024

The hearing adjourned on 20 May 2024 with the aim that by 28 May 2024, the issues with timetabling and transcript would be resolved to continue with Registrant B's evidence. On 28 May 2024, the hearing resumed with the issues relating to timetabling resolved, however, the panel was not provided with any further transcript for reference.

After further evaluation, the panel agreed a pragmatic approach to rely on individual notes along with the transcript provided to be able to continue with Registrant B's evidence. On

this basis, the panel will be extremely cautious when making its findings on facts, bearing in mind that the burden of proof rests on the NMC to prove its case. It had regard to the overall interests of justice and fairness to all parties.

The hearing therefore resumed on 29 May 2024 with Registrant B's evidence.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Norman on behalf of the NMC, and the written documentation provided by Mr Adams.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Director of Community Healthcare, NHS
- Witness 2: Lead Tissue Viability Nurse at NHS Central North West London Foundation Trust
- Witness 3: Lead Tissue Viability Nurse at NHS Central North West London Foundation Trust at the time of the incidents

- Witness 4: Student Nurse at the Home at the time of the incidents

- Witness 5: Student Nurse at the Home at the time of the incidents

The panel also considered hearsay evidence from the following NMC witness:

- Witness 6: Student Nurse at the Home at the time of the incidents

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

The panel also made the following observations:

- The panel noted many omissions in the documentation presented to it and decided that it could not therefore conclude that a missing record necessarily meant that something had not been done.

- The panel considered that the Home was in a disorganised state and had been inadequately managed. It noted that the registered manager was not a clinician. The panel heard evidence that, at the time of Mr Adams' employment at the Home, many documents were in disarray, and some care plans had not been completed. The panel heard evidence that residents were arriving for admission after 18:00, despite the Home policy that they should not be admitted after this time.

- The panel noted that although Mr Adams was appointed as clinical lead in February 2014, he was not issued with a job description and was allocated only six hours a week to carry out this role. The panel noted that Mr Adams had a break in his service at the Home from Friday 3 April until Monday 11 May 2015, when he

resumed employment there. Mr Adams resigned from the clinical lead role on 23 May 2015.

- The panel was aware that the events relating to the charges occurred some ten years ago, which understandably impacted the ability of all witnesses to recall the events accurately.

- The panel noted that the NMC rely heavily on a 260-page report by Witness 1, on which many of the charges are based, and this was based on purely documentary evidence reviewed by her some six years after the events had taken place. No parties were interviewed, including Mr Adams. The panel also note that for each registrant, the report provides an opinion.

- The panel noted that Mr Adams is of good character, with no previous regulatory findings.

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

Charge 1

That you, whilst employed as a Registered Nurse and/or Deputy Manager at the Five Acres Care Home:

1) Failed to ensure that an adequate standard of record keeping/ documentation was maintained in the home in relation to one or more residents:
    a) As set out in Schedule A;

This charge is found NOT proved on all subsections of Schedule A, aside from subsection 6 of Schedule A in relation to Resident B.

In reaching this decision, the panel took into account all of the evidence in relation to this charge.

Resident A

A-1 Did not ensure that Resident A had a Repositioning Chart in place from the date of admission on the 16/3/15.

The panel had sight of Ms 1's 'NurseExpertWitness' report, which states *'I found no repositioning charts for 16 March 2015'.*

However, the panel noted that Ms 1's report was based on available documentation, no interview of witnesses, and took place 18 months after the events in question allegedly took place.

The panel noted that on 16 March 2015, Mr Adams was not on duty. It noted evidence that Patient B was admitted on the evening of 16 March 2015 and that a repositioning chart was in place dated 17 March 2015 and more fully, on 18 March 2015. The panel considered that this was adequate in the circumstances.

The panel therefore found charge 1, with respect to this element, not proved.

A-2 Did not ensure that Repositioning Charts for Resident A between 24/3/15 and 5/4/15.

The panel had sight of Ms 1's report, which states *'There are no repositioning charts from 24 March 2015 until 5 April 2015'.*

The panel noted that there were a number of gaps in documentation throughout the paper records. The panel could not be satisfied that where a range of dates was missing, this was a result of missed entries, as opposed to lost records. Therefore, the panel could not

safely infer that where an entry was missing, this was a result of an action not being made or completed.

The panel also had sight of Resident A's repositioning charts, where it can be seen that there is an entry for 23 March 2015, but that it is at the bottom of the repositioning chart. Therefore, subsequent sheets may be missing, given that the repositioning chart had been diligently completed for the other days.

The panel therefore found charge 1, with respect to this element, not proved.

A-3 Did not ensure that the type of mattress system in use by Resident A was recorded within the patient notes.

The panel had sight of Ms 1's report, in particular *'There is no reference within the records as to what type of mattress system Resident A had and no reference as to the mattress being replaced on 25 March or at any other time.'*

The evidence does not, in the panel's view, establish that nursing staff had a duty to record this information. The panel has noted the Home policy, 'Service Users Confined to Bed Policy' which is silent in this regard. Ms 1 does not go on to state that recording this information is either mandatory or necessary.

The panel therefore found charge 1, with respect to this element, not proved.

A-4 Did not ensure that food intake charts for Resident A were kept between 16/3/15 and 28/3/15.

The panel had sight of Dr 1's Nutrition and Diabetic report, specifically:

'The nutrition intake and fluid intake was particularly poor during this period with no records being provided for the intake at Five Acres Nursing Home from 16-3-15 until 28-5-15.'

The panel also had sight of the weekly food intake charts. It noted that the bottom of the food intake chart was dated 15 March 2015, with the next page having 30 March 2015 written at the top.

The panel was of the view that the fact that the food intake charts for the dates between 16 March 2015 and 28 March 2015 were not before them is not conclusive. The panel took into account that the weekly food intake charts for Resident A outside of the dates between 16 March and 28 March 2015 show regular records being taken for March 2015 and April 2015, and it therefore appears that there are sheets missing which the panel have not been provided with.

The panel therefore found charge 1, with respect to this element, not proved.

Resident B

A-5 Between 19th February 2015 and 9th June 2015, repositioning charts were not completed.

The panel took into account Witness 1's report, which states:

'Resident B's risk assessments determined that he was at very high risk of developing pressure sores. The Waterlow Assessment was dated 4 February 2014 and had not been completed monthly, with gaps in the records from June 2014 to November 2014 and from January 2015 to April 2015. There were no repositioning charts completed between February 2015 and June 2015'

The panel also took into account Resident B's repositioning charts, where it can be seen that entries for 16, 17 and 18 February 2015 had been inputted, as well as for 19 February 2015, which shows timings recorded spanning over two days, and also record entries for 21 February 2015, which shows that there were in fact entries being made regularly. The following repositioning chart is of a different format and dated 10 June 2015, also showing regular entries.

The panel took into account that it had heard evidence that staff were using blank pieces of paper to record entries, as they were running out of paper charts and were not able to print them out, which leaves a doubt as to whether their absence is illustrative of the fact that nothing was completed or that they had run out of forms.

The panel was of the view that it is possible that there are sheets missing from the repositioning charts which are not before it. The panel noted that the repositioning charts were assiduously filled out for the dates in March 2015, but a significant gap then appeared in the evidence until June 2015.

The panel considered that there is no evidential basis for the assumptions made by Witness 1 in her report, in relation to this charge.

The panel therefore found charge 1, with respect to this element, not proved.

A-6 Between June 2014 and January 2015, Resident B's Falls Care Plan was not reviewed on a monthly basis.

The panel had sight of Witness 1's report, namely:

> *'There were gaps in the falls care plan between June 2014 and January 2015 and between January to April 2015 and the falls care plan did not reflect the personalised or changing needs for Resident B over this time.'*

The panel also had sight of Resident B's mobility falls and care plan, as well as the care plan evaluations form. It noted that on the care plan evaluations form, there is a gap between 26 June 2014 and 2 November 2014 on the same sheet of paper. This would be an unacceptable gap when it comes to reviewing a care plan, as a patient's needs could change. The next entry on the form is 11 January 2015, showing that between 26 June 2014 and 11 January 2015, only one evaluation was carried out for Resident B.

The panel further noted that the bottom of the care plan evaluations forms states:

> *'Care plans are to be checked monthly and altered as necessary'*

The panel considered that Mr Adams was appointed as clinical lead in February 2014 and would have had responsibility for ensuring that care plans were up to date, reviewed on a monthly basis and appropriately monitored.

It determined that based on the documentation before it that this was not done, and therefore find charge 1a, in respect to this element, proved.

A-7 Failed to ensure that Resident B's use of diazepam was monitored or if it was, did not ensure that the monitoring was recorded.

The panel had sight of Witness 1's report, in particular:

> *On 22 March 2015 there had been no improvement in Resident B's UTI following the start of antibiotics. Kevin Adams sent a fax to the GP outlining this. This was followed up by* [Registrant B] *on the 23 March 2015. Resident B was seen by the GP and diazepam was prescribed for his agitation. This was received by Kevin Adams who commenced this medication. The instructions by the GP were that Resident B should be followed up if needed. No documentation was evidenced to inform the decision of the GP to place Resident B on diazepam and whether this was for short term or long-term use. No care plan or protocol was initiated for his*

agitation and diazepam use. Resident B continued taking this medication until such time as this was questioned by the CCG pharmacist and a review took place. This medication was then discontinued.

The panel did not have sight of a copy of the original prescription, nor did it have sight of any of the MAR charts and therefore there was no evidence to determine when the prescription changed from a regular dose to an as required dose. The panel did have before it patient medication profiles from the dispensing pharmacists which demonstrate that between the drug being prescribed in March 2015 and October 2015, the medication was reviewed, and the prescription was subsequently changed.

The panel was also of the view, that the ultimate responsibility for reviewing prescriptions lies with the prescribing doctor.

The panel therefore found charge 1, with respect to this element, not proved.

Resident C

A-8 Resident C's Mental Capacity Plan made no reference to their diagnosis of Vascular Dementia.

The panel took into account Witness 1's report, in particular:

Whilst Resident C's GP documented that he had vascular dementia, his mental capacity plan did not refer to this. It was not updated regularly and was last updated in June 2015. This care plan was noted to be valid. This was signed by a registered nurse.

The panel also took into account Resident C's Mental Capacity Care Plan dated 6 May 2013, which indicates that *'Resident C currently has a full mental capacity. This may be reduced by illness, increase in pain or as Resident C gets older.'*

The panel considered that, whilst there is no reference to a diagnosis of vascular dementia in Resident C's Mental Capacity Plan, that does not render it inadequate. The panel considered that there was no duty to make reference to the diagnosis of vascular dementia on the Mental Capacity Plan.

The panel therefore found charge 1, with respect to this element, not proved.

A-9 Resident C's Fluid Intake Chart was not completed on a daily basis.

The panel noted the following from Witness 1's report:

> *'Fluid balance charts were not completed regularly and whilst Resident C was recorded as appearing to drink well, his granddaughter in police witness statements refuted this by stating that she would often go into the home and fluid was still on his table and would be "left to go cold" .'*

The panel also had sight of Resident C's Daily Fluid Intake Balance Charts, which do show entries being recorded in a sequential manner. The panel also noted that the dates on some of the charts had been redacted, and there were also some gaps. However, the panel was of the view that based on the information before it appears that the charts were completed on a daily basis and therefore find this charge not proved.

The panel therefore found charge 1, with respect to this element, not proved.

Resident D

A-10 Following an incident/ fall on the 10th May 2015, was not recorded and no incident report created.

The panel took into account Witness 1's report, in particular:

'During the night on the 10 May 2015 Resident D was found to be bleeding from the head. Bleeding was stopped and an ambulance crew sent to review the wound. The wound was documented as a 1cm cut to the back of her head. Observations were taken and it was deduced that no other injuries had been sustained. Kevin Adams was on duty on the 11 May 2015, the next morning. This should have been followed up. There appeared to be minimal recording of incident and Resident D's behaviour plan was not updated to mitigate against safety harms.'

The panel also took into account Resident D's daily records, in particular an entry for 9 May 2015, where Resident D's fall had been recorded:

'Resident D slept until 10am washed and dressed. Ate her lunch. Settled during the night…slept well. Monitored frequently. No concerns'

'Resident D was found on the floor at 9:15pm seen bleeding from the head. Observation done…cut to the skin…top of the head. Bleeding has been stopped…Call 999 for assessment. Ambulance crew came at 4am'

The panel noted that whilst it does not have an incident form before it, that does not mean that it was not completed, and it has no evidence before it that an incident form was not created.

The panel therefore found charge 1, with respect to this element, not proved.

A-11 No behaviour care plan was implemented to mitigate against safety harms to take account of crawling behaviour.

The panel had sight of Resident D's care plans and in particular took account of the care plan labelled 'behaviour', which had been approved by Mr Adams, which sets out how Resident D should be treated when on the floor, and how this should be mitigated:

‘Resident D likes to lay on the floor.

…

To treat Resident D with dignity.

To keep Resident D safe when on the floor, including others.

…

Resident D gets herself onto the floor during the day and she likes to lay there…if safe leave her do so and make her comfortable as this is her own behaviour.

If Resident D is in a dangerous place, trip hazard or danger to herself simply mover her to a safer environment and make her comfy there. After a while Resident D will ask to get up…During any events treat Resident D with dignity and respect at all times.’

The panel considered that whilst crawling is not mentioned in this behaviour plan, it was of the view that it is adequately covered by the care plan.

The panel therefore found charge 1, with respect to this element, not proved.

A-12 Resident D’s Death and Dying Plan was not dated.

The panel had sight of the following from Witness 1’s report on page 72:

‘Resident D had a death and dying care plan in place. This stated she had a DNAR plan in place. She did not want to be resuscitated. This had not been dated...’

The panel also had sight of Resident D's Death and Dying Care Plan. Whilst the admission date of 26 July 2014 is noted, the 'date created' has been left blank.

The panel also noted the DNAR form, which in fact had been dated with the same date.

The panel therefore found charge 1, with respect to this element, not proved.

Resident H

A-13 On the 7th March 2015, Resident H's fluids chart had not been completed.

The panel had sight of the following from Witness 1's report:

> *'Resident H had gaps in her fluid balance chart throughout the year. She often had less than 1000mls to drink and often less than 800mls. For instance, on 7 March 2015 she had a documented gap of 12 hours without fluid, on the 8 March 2015 there was a gap of 24 hours, on the 23 March 2015 she had 450mls in 24 hours, on the 18 April 2015 she took 100mls and on the 21 April 2015 there was a gap of 17 hours. This lack of fluid would have caused chronic dehydration.'*

The panel also had sight of Resident H's daily fluid intake chart dated 7 March 2015 which is partially complete with entries from 09:00 to 17:30. The panel considered that based on the evidence before it, it is impossible to determine whether or not it is simply the case that in the evening from 17:30 onwards Resident H refused any fluid intake, although it would have been best practice to note it down if so.

The panel was therefore of the view that it is factually incorrect to say that Resident H's fluid chart had not been completed on 7 March 2015.

The panel therefore found charge 1, with respect to this element, not proved.

A-14 On the 8th March 2015, Resident H's fluids chart had not been completed.

The panel also had sight of Resident H's daily fluid intake chart dated 8 March 2015, which is complete, and shows Resident H being asleep in the morning from 09:00 to 13:00, with some fluid entries from 15:00 to 18:00, and asleep again in the evening from 22:00 to 06:00 the next day.

The panel was therefore of the view that it is factually incorrect to say that Resident H's fluid chart had not been completed.

The panel therefore found charge 1, with respect to this element, not proved.

A-15 A pain care plan was not implemented for Resident H until the 26th August 2015.

The panel had sight of Witness 1's report, in particular:

> *'The CHC review on 2 July 2015 recommended that the care home refer Resident H to the GP for pain relief. She was seen by the GP on the 7 July 2015. The GP documented that Resident H was not in pain. She was written up for oramorph and paracetamol when required. A pain care plan was not developed until the 26 August 2015.'*

Aside from the extract from Witness 1's report, the panel was not taken to any other evidence to support this charge.

Additionally, the panel considered the background context of the case, the chaotic nature and the general poor standard of record keeping in the Home. Based on this, the panel was of the view that it cannot determine whether or not the pain care plan had been implemented or had been implemented but was missing or lost.

The panel therefore found charge 1, with respect to this element, not proved.

Overall finding in respect of charge 1a)

The panel concluded, based on its findings in Schedule A, that charge 1a) is found not proved on all charges, aside from Schedule A subsection 6 in relation to Resident B.

Charge 1b)

1) Failed to ensure that an adequate standard of record keeping/ documentation was maintained in the home in relation to one or more residents:

b) Generally.

The panel found this charge NOT proved.

The panel was of the view that, based on its findings in relation to charge 1a), that it cannot conclude that Mr Adams failed to ensure that an adequate standard of record keeping/documentation was maintained in the Home in relation to Residents A, B, C, D and H.

The panel therefore find this charge not proved.

Charge 2

2) Failed to ensure that Care Plans and/ or Assessments in relation to one or more residents, were created or completed in a timely manner/ if at all:
    a) As set out in Schedule B.

The panel found this charge NOT proved.

Resident A

B-1 A specific care plan for Resident A's sacral pressure sore was not created until the 19th April 2015, having been identified on the 16th March 2015

The panel had sight of Witness 1's report, as follows:

> *'10.1.26 No care plan was developed for the sacral pressure ulcer even though this had been:*
> *10.1.26.1 Documented by* [Registrant B] *and the two students on Resident A's return from Hospital;*
> *10.1.26.2 Written into the pain care plan by … ; and*
> *10.1.26.3 Documented by Kevin Adams on the patient records from 18 March 2015.'*

The panel also had sight of Resident A's daily notes dated 16 March 2015, which identify that there were pressure sores:

> *'Resident A returned from hospital at 18:00…Has had a body map done. She has 2 pressure sores'*

The panel also had sight of Resident A's care records, in particular a wound assessment document dated 18 March 2015, which refers to the pressure sores being a grade 4, and also states that a care plan is in place.

Based on this, the panel concluded that a care plan in relation to Resident A's pressure sores was in place on 18 March 2015, two days after 16 March 2015, which is well before 19 April 2015.

The panel therefore found charge 2, with respect to this element, not proved.

B-2 Did not ensure that an epileptic care plan and seizure protocols were devised in respect of Resident B.

The panel had sight of Witness 1's report, namely:

> *'10.2.78.26 Resident B also had epilepsy. During his time at Five Acres Nursing Home Resident B suffered from epileptic seizures. Despite this, Resident B did not have a care plan, risk assessment or monitoring charts in place in relation to this.*
>
> *…*
>
> *16.13.2.4 Resident B had a second seizure at 13:00. P2P visited and his urine was dipped. It was identified that he had a urine infection. Antibiotics were provided. Resident B had another seizure at 16:00 and 18:30. The GP and his daughter were informed. The GP advised that nursing staff should continue to observe Resident B. There was no care plan or protocol in place for Resident B's epilepsy and no causal link made to his seizure and UTIs.*
>
> *…*
>
> *16.14.3.2 The need for the creation of an epileptic care plan and seizure protocols with a causal link to UTIs.'*

The panel also had sight of the care plans and noted that whilst it had before it a whole series of care plans, there is not a care plan in relation to epilepsy. The panel was however of the view that just because the care plan was not presented to it, this does not mean that it was not in place, and it could be missing. The panel also had sight of the corresponding care plan index. It noted that, for example, whilst it has before it Resident B's smoking care plan, it is not present on the care plan index, which suggests the possibility of there being an epilepsy care plan which is not present on the care plan index.

The panel therefore found charge 2, with respect to this element, not proved.

B-3 Failed to create a specific care plan in relation to Resident B's pressure areas following development of wound on the 23rd June 2015.

The panel had sight of the following extract from Witness 1's report:

> *10.2.78.12 Resident B developed pressure ulcer damage. He had a right shoulder grade 2 ulcer, right lateral malleolus grade 2 ulcer, moisture lesions to his buttocks and a grade 2 and 3 pressure ulceration to both right and left hips. Body maps evidence this from 23 June 2015 onwards. These ulcers deteriorated and he was referred to the TVNs by [PRIVATE] on the 6 August 2015. He was seen by the TVN in August 2015 with subsequent follow up visits. His Waterlow was 27 (very high risk) by September 2015.*

The panel had sight of Resident B's skin integrity care plan, which has an additional handwritten updated entry dated 23 June 2015. It noted that at the bottom of the document, there is further handwritten information which appears to be a care plan, addressing the issue that Resident B has lesions on the right and left buttocks and grade 2 pressure sore to the right hip, which is specific to pressure sores and states:

> *'2 hly repositioning*
> *2 hly continence care*
> *Pro shield barrier cream to be applied'*

The panel therefore found charge 2, with respect to this element, not proved.

B-4 A personalised Falls Care Plan was not created in respect of Resident B.

The panel took into account the following extract from Witness 1's report:

> ***'10.2.78 CCG Analysis of Resident B's Care***

10.2.78.1 MK CCG analysed Resident B's care records from Five Acres Nursing Home. They stated that Resident B's fall risks were not mitigated. There were no regular reviews of risk assessments or personalised falls care plans, even though Resident B was had fallen multiple times over the last few years.'

The panel considered that it has before it Witness 1 commenting on an analysis undertaken by Milton Keynes CCG of Resident B's care records. It noted that it has been established that there are significant gaps in the care records, and the panel was therefore of the view that it cannot rely on a third-party record of potentially incomplete records, that is then commented on by another third party in a report based on incomplete records some time later.

However, the panel also had sight of Resident B's skin integrity plan, where next to the heading *'What they can or can't do (Abilities/Needs)',* there is a reference to falls:

'Resident B is at risk of falls'

The panel therefore found charge 2, with respect to this element, not proved.

B-5 A Bed Rails Assessment was not carried out until January 2015.

In reaching its decision, the panel had sight of the following from Witness 1's report:

'10.2.78.4 A bed rails assessment was not completed until the 11 January 2015 by Kevin Adams. This evidenced no use of bed rails due to Resident B's multiple falls from the bedside.'

The panel had sight of Resident B's care plan, dated 8 February 2024, which provides a reference to bedrails:

‘Use the bedrails with bumpers to minimise damage to his hands and arms when in bed, remembering his poor sight and lack of awareness’

The panel was of the view that the evidence the NMC is relying on in relation to this is insufficient.

The panel therefore found charge 2, with respect to this element, not proved.

B-6 A Manual Handling Assessment was not completed in respect of Resident B until 1/11/14.

The panel took into account the following from Witness 1’s report:

‘10.2.78.5 An initial manual handing assessment was completed in February 2014 by Kevin Adams, but this was not reviewed until the 1 November 2014 by Kevin Adams.’

The panel considered that Witness 1’s report indicates that there was a manual handling assessment completed in February 2014.

The panel has no primary evidence before it to suggest otherwise.

The panel therefore found charge 2, with respect to this element, not proved.

B-7 No Care Plan, Risk Assessment or Monitoring Charts were in place in relation to Resident B’s epilepsy.

The panel had sight of Witness 1’s report:

‘10.2.78.26 Resident B also had epilepsy. During his time at Five Acres Nursing Home Resident B suffered from epileptic seizures, despite this, Resident B did not have a care plan, risk assessment, or monitoring charts in place in relation to this.’

The panel also had sight of the care plans and noted that whilst it had before it a whole series of care plans, there is not a care plan in relation to Resident B’s epilepsy. The panel was however of the view that just because the care plan is not there does not mean that it was not in place, and it could be missing. The panel also had sight of the corresponding care plan index. It noted that, for example, whilst it has before it Resident B’s smoking care plan, it is not present on the care plan index, which suggests the possibility of there being an epilepsy care plan which is not present on the care plan index.

The panel therefore found charge 2, with respect to this element, not proved.

B-8 A Wheelchair Risk Assessment not implemented until July 2015.

The panel had sight of the following from Witness 1’s report, which sets out that a wheelchair risk assessment was not put in place until July 2015:

10.5.26 Resident F used a wheelchair. A wheelchair risk assessment was put in place but not until July 2015. This was not personalised and did not include the risk mitigation of a lap strap for fall minimisation when on outings with the family. It was acknowledged after a fall with her husband that she would need a wheelchair lap strap to minimise harm of falling from the wheelchair as well as a wheelchair review.

The panel however considered that it has no primary evidence before it given that Witness 1’s report is a third-party source. It also took into account that documents are missing from the NMC evidence, and there is no way to conclude whether this may or may not include the wheelchair risk assessment.

The panel therefore found charge 2, with respect to this element, not proved.

B-9 No personalised seating plan was in place for Resident F.

The panel noted that it was not directed to any primary evidence by the NMC and therefore not able to come to a conclusion as to whether or not a personalized seating plan was in place for Resident F.

The panel therefore found charge 2, with respect to this element, not proved.

B-10 No care plans or preventative strategies were in place from March 2015 to mitigate Resident G's pressure ulcer development.

The panel noted the following from Witness 1's report:

> *10.6.19 On 6 March 2015 it was documented that Resident G had redness to his buttocks.* [Registrant B] *was on duty, but no management strategies and/or care plans were put in place. By the 18 March 2015 it was noted that there was a red area to his heel. A 2-layer bandage was applied, and Resident G's legs were elevated using a cushion. On the 19 March 2015 it was documented that thi bandage was intact, and his legs were elevated on a cushion. There was no further reference made to his heel redness within the patient notes until the 2 April 2015 when it is documented that Resident G had a pressure sore to his right heel 2 cm x 3 cm and left heel 3 cm x 4 cm. Both were black and necrotic. These were dressed and a wound evaluation form completed by* [Registrant B]*. No care plan was developed until the 27 April 2015 and 3 May 2015 respectively.*

The panel was referred to Resident G's, care plan which shows a review date of 3 May 2015. The date '3 April 2015' can also be seen noted at the top of the care plan, which the panel noted succeeds March 2015. The panel has no other primary evidence before it.

The panel has before it Resident G's care plan dated 3 April 2015 in relation to pressure ulcers, which demonstrates that there are some care plan strategies in place after March 2015. However, the panel is not clear as to whether there are any other care plans, as they could be missing.

The panel therefore found charge 2, with respect to this element, not proved.

B-11 No care plans or preventative strategies were in place for the management of the dry and fragile area of skin on Resident G's left heel identified on the 2nd February 2015.

The panel took into account the following from Witness 1's report:

> *10.6.18 On 2 February 2015 it was documented that Resident G had a dry fragile area on his left heel 1.5 cm x 3 cm. A body map was completed, proshield barrier cream was applied, but no care plan or strategies put in place for management. Both* [Registrant B] *and Kevin Adams were on duty.*

The panel noted that it had also been referred to a Wound Evaluation Form labelled 'left heel', which appears to be incorrectly attached to a care plan labelled 'right heel' which refers to pressure ulcers which was identified on 2 February 2015, prior to it developing into an ulcer by 28 April 2015. The panel noted that it has nothing before it as to the earlier point when this could have been prevented.

The panel concluded that the only evidence in support of this is Witness 1's report, which was produced five years following the events in question and based on incomplete documents.

The panel therefore found charge 2, with respect to this element, not proved.

B-12 Redness to Resident G's buttocks was identified on the 6th March 2015. No care plan was developed until the 27th April 2015.

The panel had sight of the following from Witness 's report:

> *10.6.19 On 6 March 2015 it was documented that Resident G had redness to his buttocks.* [Registrant B] *was on duty, but no management strategies and/or care plans were put in place. By the 18 March 2015 it was noted that there was a red area to his heel. A 2-layer bandage was applied, and Resident G's legs were elevated using a cushion. On the 19 March 2015 it was documented that this bandage was intact, and his legs were elevated on a cushion. There was no further reference made to his heel redness within the patient notes until the 2 April 2015 when it is documented that Resident G had a pressure sore to his right heel 2 cm x 3 cm and left heel 3 cm x 4 cm. Both were black and necrotic. These were dressed and a wound evaluation form completed by* [Registrant B]*. No care plan was developed until the 27 April 2015 and 3 May 2015 respectively.*

The panel also had sight of Resident G's care plan, which was created on 27 April 2015. It noted that Resident G was in hospital between 6 April 2015 and 23 April 2015, so the care plan would have been created when Resident G returned to the Home following their hospital admission, which would be a reasonable time period.

In considering whether a care plan should have been in place prior to 6 April 2025, the panel noted that there is an absence of evidence to support this, due to incomplete records before the panel and the possibility of lost documentation. The panel concluded that the evidence before it does show that care plans were being generally produced by the Home.

The panel therefore found charge 2, with respect to this element, not proved.

B-13 A Behaviour Care Plan and Mental Capacity Care Plan in respect of Resident H were not developed until the 21st July 2015.

The panel noted the following extract from Witness 1's report:

> *10.7.8 A behaviour care plan was developed on 21 July 2015 which documented Resident H's agitation.*

The panel also had sight of Resident H's care plan dated 21 July 2015. The panel noted that there had been a change in the style of the care plan and appeared to be more 'robust', with a typed care plan as opposed to a handwritten care plan, as well as an additional column showing if the plan had been updated or discontinued. The panel considered that the previous care plans used are a single sheet.

The panel noted that it has no information before it as to whether the Home had either decided to move to a new format of care plans or had decided to transfer data from the old care plan format to the new care plan format. The panel further considered that there could potentially be a missing care form document in the old-style format, which predates the care plan dated 21 July 2015.

The panel therefore found charge 2, with respect to this element, not proved.

B-14 A Personal Cleaning and Dressing Care Plan was not developed until the 23rd July 2015.

The panel had sight of the following from Witness 1's report:

> *10.7.10 A personal cleansing ad dressing care plan was developed on 23 July 2015.*

The panel also had sight of Resident H's care plan dated 23 July 2015, which is set out in the new style format, and is extensively typed up. It considered that due to this and taking into account that Resident H was admitted on 9 October 2024, it is unclear whether Resident H's care plan was originally in an old handwritten format and was subsequently transferred to the new typed up format or whether the care plan was created in the new format. The panel concluded that there is no primary evidence before it that there was not a previous care plan prior to 23 July 2015.

The panel therefore found charge 2, with respect to this element, not proved.

B-15 No care plan was developed in respect of Resident H's right ankle pressure ulcer which was identified on the 26th December.

The panel had sight of the following extract from Witness 1's report:

> *10.7.40 On 26 December 2014 it is documented that Resident H developed a right outer ankle pressure ulcer. No care plan was put in place.*

The panel was also referred to Resident H's skin integrity care plan, which is undated, but was updated on 20 June 2015 following a Tissue Viability Nurse (TVN) visit. It considered that there is no information as to when the care plan was introduced as there is no date.

The panel concluded that the primary evidence it has been directed to shows a skin integrity care plan, but that it is the only care plan before it, and there could be other care plans due to incomplete documentation from the Home.

The panel therefore found charge 2, with respect to this element, not proved.

B-16 Following identification of a pressure ulcer Resident H's left ankle on the 12th January 2015, no Care Plan, Wound Evaluation form or Body Map was developed until the 11th February 2015.

The panel noted the following from Witness 1's report:

> *10.7.41 On 12 January 2015 it was documented that Resident H had a left ankle ulcer. No care plan, wound evaluation form or body map was put in place until 11 February 2015, by Kevin Adams. This care plan documented that Resident H had both left and right ulcerated/scabbed ankles. The left ankle was documented as a grade 2 pressure ulcer. There was no referral to the TVNs or SOVA completed at this time.*

The panel has not been referred to any primary evidence in relation to this.

The panel therefore found charge 2, with respect to this element, not proved.

B-17 A Pain Care Plan was not implemented for Resident H until the 26th August 2015.

The panel had sight of Witness 1's report, in particular:

> *10.7.54 The CHC review on 2 July 2015 recommended that the care home refer Resident H to the GP for pain relief. She was seen by the GP on the 7 July 2015. The GP documented that Resident H was not in pain. She was written up for oramorph and paracetamol when required. A pain care plan was not developed until the 26 August 2015.*

The panel took into account that the GP had documented that Resident H was not in pain but was written up with a medical direction for pain relief when required.

The panel was not provided with any primary evidence and is therefore not able to conclude whether or not a care plan existed.

The panel therefore found charge 2, with respect to this element, not proved.

Charge 3)

3) Failed to ensure that Care Plans and/ or Assessments were reviewed and/or updated on a regular basis in relation to one or more Residents and/ or ensure that such reviews were undertaken by staff at the home:

a) As set out in Schedule C;
b) Generally.

The panel found this charge in its entirety NOT proved, except for item eight on Schedule C.

C-1 Did not evaluate Resident A's care plan after the 7th May 2015.

The panel had sight of the Milton Keynes Contract Monitoring File Review Notes, dated 10 August 2015. The panel found this to be fairly contemporaneous. It took into account that under the heading 'Care plan evaluation', review dates are noted as 17 April 2015 and 7 May 2014 *' – should be done monthly or as changes occur'*

The panel also had sight of Resident A's care plan evaluations document, with entries for the dates 17 March 2015, 17 April 2015 and 7 May 2015.

The panel noted that Resident A passed away on 11 June 2015 and it therefore cannot be expected for a care plan to be produced after 7 May 2015. Whilst there was a duty to update care plans on a regular basis, in the particular circumstances of this case, that was discharged.

The panel therefore found charge 3, with respect to this element, not proved.

C-2 Did not evaluate Resident A's Nutrition care plan after the 18th May 2015.

The panel took into account Resident A's care plan evaluations document, where an entry can be correctly seen on 18 May 2015. It considered that by the time another evaluation was due, Resident A had passed away.

The panel therefore found charge 3, with respect to this element, not proved.

C-3 Did not evaluate Resident A's Death/ Dying care plan during their time at the home.

The panel had sight of Resident A's Death/Dying care plan. The panel took into account that there is no date on the care plan as to when it was created, and next to 'review date', it is noted 'monthly/PRN'. The panel noted that it has no evaluation sheet before it which shows whether or not it was updated.

The panel therefore found charge 3, with respect to this element, not proved.

C-4 Did not evaluate Resident A's Hygiene care plan after the 6th May 2015.

The panel had sight of Resident A's care plan evaluations, which shows an entry made dated 31 May 2015. The panel noted that Resident A passed away on 11 June 2015 and therefore cannot be expected for a Hygiene care plan to have been produced for June 2015.

The panel therefore found charge 3, with respect to this element, not proved.

C-5 Did not evaluate Resident A's incontinence plan after the 7th May 2015.

The panel noted that it has been referred to a care plan evaluations document for Resident A, with the last entry being 7 May 2015. The panel noted that Resident A had passed away on 11 June 2015. Whilst there was a duty to update care plans on a regular basis, in the particular circumstances of this case, that was discharged.

The panel therefore found charge 3, with respect to this element, not proved.

C-6 Did not evaluate Resident A's night sleeping care plan after 3rd May 2015.

The panel was referred to Resident A's care plan evaluations, which shows sequential entries, namely on 25 March 2015, 28 April 2015 and 3 May 2015. The panel also had sight of a second care plan evaluations document showing an entry also made on 3 May 2015.

The panel noted that Resident A had passed away on 11 June 2015. Whilst there was a duty to update care plans on a regular basis, in the particular circumstances of this case, that was discharged.

The panel therefore found charge 3, with respect to this element, not proved.

C-7 Did not review/ensure that Resident B's care plan was regularly reviewed.

The panel had sight of the following from Witness 1's report:

> *10.2.78 CCG Analysis of Resident B's Care*
>
> *10.2.78.1 MK CCG analysed Resident B's care records from Five Acres Nursing Home. They stated that Resident B's fall risks were not mitigated. There were no regular reviews of risk assessments or personalised falls care plans, even though Resident B was had fallen multiple times over the last few years.*

The panel was also referred to a care plan evaluations form for Resident B, where there were a number of gaps on the same sheet, for example from June 2014 to November 2014, and from January 2015 to April 2015. Mr Adams had a duty both to ensure that care plans were updated on a regular basis, and to update care plans when he was caring directly for Resident B. The panel note that at the foot of the care plan evaluations form, it

is stated that they should be checked monthly. The panel also noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly. Therefore, there are gaps of two months and four months, and the panel consider that this shows neither monthly checks nor regular entries.

The panel therefore found charge 3, with respect to this element, proved.

C-8 Did not review Resident B's Falls Care Plan on a regular basis between June 2014 and January 2015.

The panel had sight of the following from Witness 1's report:

> *10.2.78.3 There were gaps in the falls care plan between June 2014 and January 2015 and between January to April 2015 and the falls care plan did not reflect the personalised or changing needs for Resident B over this time.*

The panel had sight of Resident B's mobility and falls care plan, which was created on 6 February 2014, and was last updated on 7 June 2015. The panel noted that the evaluations sheet showed that there were gaps in review between June 2014 and November 2014, between November 2014 and January 2015, and between January 2015 and April 2015. Mr Adams had a duty both to ensure that care plans were updated on a regular basis, and to update care plans when he was caring directly for Resident B. The panel note that at the foot of the care plan evaluations form, it is stated that they should be checked monthly. The panel noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly.

The panel therefore found charge 3, with respect to this element, proved.

C-9 Did not ensure that Resident B's Waterlow Assessment and Pressure Risk were reviewed monthly between January 2015 and April 2015.

The panel was referred to Witness 3's witness statement but could not find anything relevant to this element of the charge.

The panel considered that the only reference before it in relation to this element of the charge could be found in the following extract from Witness 1's report:

> *10.2.78.9 Resident B's risk assessments determined that he was at very high risk of developing pressure sores. The Waterlow Assessment was dated 4 February 2014 and had not been completed monthly, with gaps in the records from June 2014 to November 2014 and from January 2015 to April 2015. There were no repositioning charts completed between February 2015 and June 2015.*

The panel noted that it has no primary evidence in relation to this element of the charge.

The panel therefore found charge 3, with respect to this element, not proved.

C-10 Did not ensure that Resident B's Risk Assessment was regularly reviewed, despite Resident B having several falls between the 10th April 2014 and 11th January 2015.

The panel had sight of the following from Witness 1's report:

> *10.2.78.1 MK CCG analysed Resident B's care records from Five Acres Nursing Home. They stated that Resident B's fall risks were not mitigated. There were no regular reviews of risk assessments or personalised falls care plans, even though Resident B was had fallen multiple times over the last few years.*

The panel also had sight of Resident B's Falls Risk Assessment Tool (FRAT), which shows that there were gaps in reviews between April 2014 and November 2014 and a further omission in December 2014.

The panel noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly. Therefore, the panel noted that Mr. Adams had a duty both to ensure that risk assessments were updated on a monthly basis, and to update risk assessments when he was caring directly for Resident B.

The panel therefore found charge 3, with respect to this element, proved.

C-11 Resident B's risk assessment was not reviewed after March 2015.

The panel had sight of the following from Witness 1's report:

> *10.2.78.2 The risk assessment was reviewed once between the 10 April 2014 and 11 January 2015. It was not reviewed again from the 3 March 2015.*

The panel considered that it has no evidence before it as to what risk assessment is being referred to.

The panel therefore found charge 3, with respect to this element, not proved.

C-12 Resident B's moving and positioning care plan was not updated monthly to reflect their changing needs.

The panel had sight of the following from Witness 1's report:

> *10.2.78.6 A moving and positioning care plan was developed in February 2014. This was not updated monthly to reflect his changing needs*

The panel was also referred to Resident B's moving and positioning care plan, which was created on 8 February 2014, and was last updated on 18 June 2015. The panel noted that there was a gap in reviews between June 2014 and November 2014. Mr. Adams had a

duty both to ensure that care plans were updated on a regular basis, and to update care plans when he was caring directly for Resident B. The panel note that at the foot of the care plan evaluations form, it is stated that they should be checked monthly. The panel noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly.

The panel therefore found charge 3, with respect to this element, proved.

C-13 Resident B's skin integrity plan was created in February 2014 but it was not reviewed/ updated until March 2015.

The panel took into account the following extract from Witness 1's report:

> *10.2.78.8 MK CCG stated that Resident B's skin integrity care plan which was developed in February 2014 had not been updated until March 2015 and then stopped after June 2015. Equally his pressure sore risk was not mitigated.*

The panel noted that the care plan evaluations form shows the first evaluation being on 2 March 2015, written at the top of the evaluations sheet presented to the panel. However, the panel considered the likelihood of there being missing earlier care plan evaluation sheets, given that Resident B's admission was in February 2014.

The panel therefore found charge 3, with respect to this element, not proved.

C-14 Resident B's bowel assessment was not updated between June and November 2014.

The panel were not taken to any primary evidence in relation to this element of the charge.

The panel therefore found charge 3, with respect to this element, not proved.

C-15 Resident C's mental capacity plan was not updated on a monthly basis.

The panel had sight of the following from Witness 1's report:

> *10.3.5 Whilst Resident C's GP documented that he had vascular dementia, his mental capacity plan did not refer to this. It was not updated regularly and was last updated in June 2015. This care plan was noted to be valid. This was signed by a registered nurse.*

The panel noted the Individual Planning and Review Policy of the Home specifies that care plans should be reviewed monthly. Therefore, the panel noted that Mr. Adams had a duty both to ensure that care plans were updated on a monthly basis, and to update care plans when he was caring directly for Resident C.

The single care plan evaluation sheet presented to the panel showed that there was a review in June 2014 and then a gap until January 2015.

The panel therefore found charge 3, with respect to this element, proved.

C-16 Resident C's falls risk assessment was not updated following a number of falls between March-May 2015.

The panel had sight of the following from Witness 1's report:

> *10.3.19 Resident C had several falls (31 March 2015, 6 April 2015, 16 April 2015, 26 April 2015 and 21 May 2015). His falls risk assessment was not updated to reflect an increased fall risk (remaining as medium risk with no concerns identified) and no causal link was made to Resident C having a UTI and falling.*

The panel was referred to a sheet for Resident C headed 'nursing goals and objectives number 4' which has 'mobility and falls' handwritten at the top of the sheet. This form is

not headed risk assessment, unlike other documentation which the panel has seen. Therefore, the panel considered that it has not been presented with the risk assessment document.

The panel therefore found charge 3, with respect to this element, not proved.

C-17 Resident C's diabetic care plan was not regularly updated.

The panel had sight of the following from Witness 1's report:

> *10.3.15 As a diabetic, a care plan in relation to Resident C's diabetes was put in place on 6 May 2013. It documented that his blood sugar should remain between 4-7mmols. It is not clear how often his blood sugars should have been checked on this plan. This care plan was not updated monthly.*

The panel had sight of Resident C's diabetes care plan, which was created on 6 May 2013. The panel also had sight of the care plan evaluations form and noted that there was a gap between June 2014 and January 2015 on the single sheet presented to it.

The panel noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly. Therefore, the panel noted that Mr. Adams had a duty both to ensure that risk assessments were updated on a monthly basis, and to update risk assessments when he was caring directly for Resident C.

The panel therefore found charge 3, with respect to this element, proved.

C-18 Resident C's waterlow assessment was not updated monthly between June 2014 and January 2015

The panel was not referred to any primary evidence in relation to this element of the charge.

The panel therefore found charge 3, with respect to this element, not proved.

C-19 Resident C's hygiene plan was not updated between June 2014 and January 2015.

The panel took into account the following from Witness 1's report:

> *'10.3.12 Resident C's hygiene plan was not updated regularly and not updated at all from March 2014 to January 2015. Resident C did not appear to be offered a bath, shower or hair wash regularly. Patient records stated that he was offered a bath or shower on an ad hoc basis with some months having between one to three baths or showers and others none. This corresponds with suggestions from the family in police witness statements that Resident C always looked unkempt.'*

The panel had sight of Resident C's hygiene care plan, which was created on 6 May 2013. The panel also had sight of the care plan evaluations form and noted that there was a gap between June 2014 and January 2015 on the single sheet presented to it.

The panel noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly. Therefore, the panel noted that Mr. Adams had a duty both to ensure that this hygiene plan was updated on a monthly basis and when he was caring directly for Resident C.

The panel therefore found charge 3, with respect to this element, proved.

C-20 Resident C's care plan for communication was not updated between June 2014 and January 2015.

The panel took into account the following from Witness 1's report, which sets out that the care plan was not updated from March 2014 to January 2015, and does not correspond to this element of the charge:

> *'10.3.13 Resident C's care plan for communication i.e., hearing, and poor eyesight was not updated from March 2014 to January 2015. This was not personalised for his eyesight or linked to his falls risks.'*

The panel had sight of Resident C's communication care plan, created on 6 May 2013. The panel also had sight of the care plan evaluations form and noted that there was a gap between June 2014 and January 2015 on the single sheet presented to it.

The panel noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly. Therefore, the panel noted that Mr. Adams had a duty both to ensure that this communication plan was updated on a monthly basis and when he was caring directly for Resident C.

The panel therefore found charge 3, with respect to this element, proved.

C-21 Resident C's continence plan was not updated between June 2014 and January 2015.

The panel took into account the following from Witness 1's report, which sets out that the care plan was not updated from March 2014 to January 2015, and does not correspond to this element of the charge:

> *'10.3.14 Resident C's continence care plan was not updated from March 2014 to January 2015.'*

The panel had sight of Resident C's continence care plan, created on 6 May 2013. The panel also had sight of the care plan evaluations form and noted that there was a gap between June 2014 and January 2015 on the single sheet presented to it.

The panel noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly. Therefore, the panel noted that Mr. Adams had a duty both to ensure that this continence plan was updated on a monthly basis and when he was caring directly for Resident C.

The panel therefore found charge 3, with respect to this element, proved.

C-22 Resident C's care plan for diabetes was not reviewed between June 2014 and 22nd January 2015.

> *'10.3.15 As a diabetic, a care plan in relation to Resident C's diabetes was put in place on 6 May 2013. It documented that his blood sugar should remain between 4-7mmols. It is not clear how often his blood sugars should have been checked on this plan. This care plan was not updated monthly.'*

The panel had sight of Resident C's diabetes care plan, created on 6 May 2013. The panel also had sight of the care plan evaluations form and noted that there was a gap between June 2014 and January 2015 on the single sheet presented to it.

The panel noted the Individual Planning and Review Policy of the Home specifies that care plans and risk assessments should be reviewed monthly. Therefore, the panel noted that Mr. Adams had a duty both to ensure that this diabetes plan was updated on a monthly basis and when he was caring directly for Resident C.

The panel therefore found charge 3, with respect to this element, proved.

C -23 The Manual Handling Assessment was not reviewed regularly in 2015.

The panel took into account the following extract from Witness 1's report:

> *'10.3.21 A manual handling assessment was undertaken on the 5 May 2013. This evidenced that Resident C had poor eyesight and therefore the environment needed to be made safe for him. This assessment was only updated once in 2014 and not regularly in 2015. In April and May 2015, the assessment stated "no change", even though he had had multiple falls and had been referred to the Falls Team. Following his last fall on the 21 May 2015, Resident C was referred to the Falls Team. He was seen on the 28 May 2015: a rollator and Velcro fastening slippers were advised as a means to ensuring that he was safe when walking.'*

The panel was however not referred to any primary evidence in relation to this element of the charge.

The panel therefore found charge 3, with respect to this element, not proved.

C-24 Nutrition care plan was not regularly reviewed.

The panel had sight of Witness 1's report regarding Resident D's nutrition care plan and noted that this did not address errors in the nutrition care plan review.

The panel also had sight of Resident D's nutrition care plan, with the date 26 July 2014 handwritten at the top right-hand corner of the sheet, followed by a care plan evaluations sheet for Resident D with no heading, with handwritten entries for May 2015 and June 2015. The panel considered that this care plan evaluations sheet shows two entries for consecutive months and considers that earlier sheets may have been missing from the evidence presented to it.

The panel therefore found charge 3, with respect to this element, not proved.

C-25 Diabetic care plan was not updated before January 2015.

The panel was referred to Witness 1's report:

> *10.4.7 Resident D was documented as being diabetic. A diabetic care plan was developed on 1 October 2014 which stated that her blood sugars should be undertaken weekly. Her blood sugars were documented to have a minimum and maximum threshold of between 4-7 mmols. The care plan was not updated until January 2015. I have no records of Resident D's blood sugars being recorded weekly.*

The panel however was not referred to any primary evidence in relation to this element of the charge.

The panel therefore found charge 3, with respect to this element, not proved.

C-26 Communications care plan was not regularly reviewed between October 2014 and January 2015.

The panel had sight of the following from Witness 1's report:

> *10.4.10 Resident D had a communications care plan in place This was created in October 2014 and was personalised to include her agitation and hearing problem. Whilst not regularly reviewed until January 2015 this was reviewed thereafter.*

The panel also had sight of Resident D's communication care plan, which was created on 1 October 2014. The panel also saw the care plan evaluations sheet which followed, and included entries for January 2015, February 2015, April 2015, May 2015 and June 2015. However, the panel considered that there could have been earlier missing care plan evaluation sheets.

The panel therefore found charge 3, with respect to this element, not proved.

C-27 Behaviour Care Plan was not reviewed.

The panel had sight of the following from Witness 1's report:

> *10.4.11 Resident D had a behaviour care plan in place. This plan stated that she liked to lie on the floor and could become aggressive. This plan was not reviewed.*

The panel also had sight of Resident D's behaviour care plan, which was created on 1 October 2014, and does not provide any dates as to when the care plan was last updated. The panel were taken to some daily records which have been regularly completed but also had before it a blank care plan evaluations sheet with no title. Without clear evidence that reviews had not taken place, the panel could not find this element proved.

The panel therefore found charge 3, with respect to this element, not proved.

C-28 Bed Rails assessment was not reviewed for three months following admission to the home.

The panel was referred to the following extract from Witness 1's report:

> *'10.4.13 A bed rails assessment was completed on Resident D's admission and was not reviewed for the first 3 months of her admission…'*

The panel has before it no other primary evidence to support this element of the charge.

The panel therefore found charge 3, with respect to this element, not proved.

C-29 Resident D's falls care plan was not reviewed on a monthly basis in 2014 and 2015 as stipulated in October 2013.

The panel was not taken to any evidence regarding a falls care plan for Resident D.

The panel therefore found charge 3, with respect to this element, not proved.

C-30 Resident D's Death and Dying Plan was not reviewed whilst at the home.

The panel took into account the following from Witness 1's report:

> *10.4.18 Resident D had a death and dying care plan in place. This stated she had a DNAR plan in place. She did not want to be resuscitated. This had not been dated or reviewed.*

The panel also had sight of Resident D's death and dying care plan, with 26 July 2014 handwritten at the top right-hand corner with a monthly review schedule. The panel also had sight of a care plan evaluations sheet, which is completely blank. The panel were therefore not able to conclude what the care plan evaluations sheet refers to.
The panel therefore found charge 3, with respect to this element, not proved.

C-31 Diabetic care plan and weekly blood sugar check was not regularly reviewed in 2015

The panel was not referred to any primary evidence in relation to this charge and therefore found charge 3, with respect to this element, not proved.

C-32 Resident G's BMI and MUST score was not updated after December 2014.

The panel was not referred to any primary evidence in relation to this charge and therefore found charge 3, with respect to this element, not proved.

C-33 Resident G's oral health assessment was not updated on a monthly basis.

The panel was not referred to any primary evidence in relation to this charge and therefore found charge 3, with respect to this element, not proved.

C-34 Resident G's bowel assessment was not updated on a monthly basis from October 2014.

The panel was not referred to any primary evidence in relation to this charge and therefore found charge 3, with respect to this element, not proved.

C-35 Resident G's falls assessment was not updated on a regular basis from the 15th October 2014.

The panel was not referred to any primary evidence in relation to this charge and therefore found charge 3, with respect to this element, not proved.

C-36 Resident G's continence care plan was not regularly reviewed.

The panel had sight of Resident G's continence care plan, which was created on 15 October 2014. The panel also had sight of two care plan evaluations sheets, which were not titled, showing two separate entries out of sequence. The panel was not confident that there were not other evaluation sheets which had not been presented to it.

The panel therefore found charge 3, with respect to this element, not proved.

C-37 Resident G's hygiene care plan was not reviewed on a regular basis from the 15th October 2014.

The panel had sight of Witness 1's report, in particular:

> *'10.6.13 A hygiene care plan was developed on 15 October 2014 This was not reviewed regularly…'*

The panel was referred to Resident G's hygiene care plan, which was created on 15 October 2014, but does not provide any further dates as to when the care plan was

updated. The panel also considered Resident G's care plan evaluations sheet, which provides entries for 28 December 2014 and on 6 April 2015. The panel was of the view that this does show a gap of four months, and that there was a duty for Mr Adams to ensure review of care plans monthly.

The panel therefore found charge 3, with respect to this element, proved.

C-38 Resident G's communication care plan was not reviewed on a regular basis from the 15th October 2014.

The panel had sight of Witness 1's report, in particular:

> *10.6.14 A communication care plan was developed on 15 October 2014. This was not reviewed regularly.*

The panel was referred to Resident G's communication care plan, which was created on 15 October 2014, but does not provide any further dates as to when the care plan was updated. The panel also considered Resident G's care plan evaluations sheet, which provides entries for 28 December 2014 and on 6 April 2015. The panel was of the view that this does show a gap of four months, and that there was a duty for Mr Adams to ensure review of care plans monthly.

The panel therefore found charge 3, with respect to this element, proved.

C-39 Resident G's manual handling assessment was not updated in 2015.

The panel had sight of Witness 1's report, specifically:

> *10.6.16 He used a hoist and wheelchair. His manual handling assessment was undertaken on 20 October 2014. This was not updated in 2015.*

The panel considered that it does not have before it any primary evidence in relation to this element of the charge.

The panel therefore found charge 3, with respect to this element, not proved.

C-40 Resident H's mobility plan was not reviewed before May 2015.

The panel had sight of Witness 1's report, specifically:

> *10.7.18 Resident H's mobility plan was first evaluated on 3 May 2015. This plan stated that she needed 2 staff to assist her to use the standing hoist (this plan is undated).*

The panel had sight of Resident H's mobility care plan. It noted that the care plan evaluations sheet provides entries for 3 May 2015 and 18 June 2015 and consider that there may be other missing sheets which are not before the panel.

The panel therefore found charge 3, with respect to this element, not proved.

Overall, the panel find charge 3a proved with respect to Schedule C elements 7,8,10,17,19,20,21,22,37 and 38.

Regarding charge 3b, the panel considered that the word 'generally' implies that all or most of the elements of Schedule C must be engaged to be found proved. Therefore, the panel finds charge 3b not proved.

Charge 4)

4) Failed to adequately document wounds, bruises and dietary needs appropriately or at all in relation to one or more Residents and/ or ensure that such documentation was undertaken by staff at the home:

a) As set out in Schedule D;
b) Generally.

D-1 Failed to record the depth of sacral ulcer when completing a wound evaluation form on the 18th March 2015

The panel was taken to the following extract from Witness 1's report:

> *10.1.31 On 18 March 2015, a wound evaluation form was created by Kevin Adams he documented that the sacral ulcer was 80% granulation tissue and 20% necrotic. It was measured as 3.5 x 5.0cm. No depth was documented.*

The panel took account of Ms 1's report on Resident A dated 19 December 2016 on Nursing and Tissue Viability, which does not reference a failure to record depth.

The panel were not able to identify a policy which specified that depth should be recorded, neither did it identify any advice from the tissue viability service that depth should be routinely recorded. The panel therefore was not satisfied that a duty had been established on Mr. Adams to record wound depth or to ensure that this was done.

The panel also had sight of Resident A's wound evaluation form, which shows an entry for 8 March 2015 made for width and length of the wound measurement.

The panel therefore found charge 4, with respect to this element, not proved.

D-2 Failed to record the depth of sacral ulcer when completing a wound evaluation form on the 23rd March 2015

The panel took account of Ms 1's report on Resident A dated 19 December 2016 on Nursing and Tissue Viability, which does not reference a failure to record depth.

The panel were not able to identify a policy which specified that depth should be recorded, neither did it identify any advice from the tissue viability service that depth should be routinely recorded. The panel therefore was not satisfied that a duty had been established on Mr. Adams to record wound depth or to ensure that this was done.

The panel also had sight of Resident A's wound evaluation form, which shows an entry for 23 March 2015 made for width and length of the wound measurement.

The panel therefore found charge 4, with respect to this element, not proved.

D-3 Failed to mention sacral ulcer within a safeguarding alert

The panel had sight of the Pressure Area Care and Use of Pressure Relieving Equipment Policy, which was implemented on 13 December 2014. It considered in particular the following:

> *'The Home Manager (or person in charge) has a responsibility to report pressure sores, ulcers or moisture lesions to the Referral Management Team at Social Services under SOVA if they are thought to be the result of poor care practices.'*

The panel also had sight of Witness 1's report:

> *10.1.38 Resident A was seen by [Witness 2] TVN with Kevin Adams on the 25 March 2015. Summary: Hospital Acquired Category 3 pressure sore to heel 3.5cm x 4.5cm. This was black and necrotic. It was stated that Five Acres Nursing Home had completed a safeguarding alert.*
>
> *10.1.39 There was no mention of the sacral ulcer and the TVN in her police witness statement recalls asking Kevin Adams whether all other pressure areas were intact. Kevin Adams confirmed that there were no other pressure ulcers.*

The panel noted that the evidence before it states that it is not disputed that a safeguarding alert had been completed by the Home, but rather that there was no mention of the sacral ulcer within the safeguarding alert. The panel however considered that it does not have before it the safeguarding report to determine whether the sacral ulcer was mentioned or not.

The panel therefore found charge 4, with respect to this element, not proved.

D-4 The "wound bed" section on a Wound Evaluation Chart dated 25/3/15 was crossed through/ incomplete even though Resident A had a Grade 2 pressure wound.

The panel had sight of Resident A's Wound Evaluation Form, specifically under the entry dated 25 March 2015 under 'Wound Bed, which has been crossed through. The panel noted that there are also entries for other evaluations, such as 'Surrounding Skin' and 'Exudate (amount)'.

The panel considered that it has no evidence before it as to the circumstances under which this was done, and whether or not there is a reason for why this was done. The panel noted the other entries which were made which demonstrate that the wound had been evaluated on 25 March 2015. It considered that based on the Pressure Area Care and Use of Pressure Relieving Equipment Policy, there is no duty to complete the form, and it is not clear that there was a breakthrough the skin.

In the context of what else is recorded about this wound, it is reasonable to conclude that there would have been nothing to report with respect to the wound bed.

The panel therefore found charge 4, with respect to this element, not proved.

D-5 On the 19th May 2015, after changing Resident A's sacral ulcer dressing, did not record any further details on the condition of that ulcer.

The panel considered the following from Witness 1's report:

> *10.1.86 On the 19 May 2015 Kevin Adams renewed Resident A's sacral dressing, the ulcer measured 8.5 cm x 6.5 cm. No other documented comments were made in relation to the status of the wound bed.*

The panel also had sight of Resident A's daily notes, where a handwritten entry for 19 May 2015 can be seen:

> *'Dressing to sacrum reviewed 8.5 x 6.5 cm approx., CIP updated.'*

The panel was of the view that there is no duty or requirement, or practice to record all the details of the wound in the daily notes, and that this would ordinarily be recorded on an evaluation form. The panel has not been provided with a copy of the evaluation form to determine whether or not this had been done. The panel also took into account that Witness 1's report does not refer to Resident A's daily notes, only the wound evaluation form.

The panel therefore found charge 4, with respect to this element, not proved.

D-6 On the 1st June 2015, after changing Resident A's sacral ulcer dressing, did not record any further details on the condition of that ulcer.

The panel had sight of Resident A's daily notes, where an entry for 1 June 2015 can be seen:

> *'Dressing to sacrum reviewed'*

The panel considered that the NMC has not established that it was policy or practice to fully articulate details of care that would normally be recorded elsewhere in the patient record, for example body maps or evaluation charts.

In the absence of a wound evaluation document, the panel was of the view that it cannot conclude that the document was not completed.

The panel therefore found charge 4, with respect to this element, not proved.

D-7 Did not complete/ ensure that a body map was completed after the 16th March 2015.

The panel had sight of the following from Witness 1's report:

> *10.1.20 Resident A returned to Five Acres Nursing Home on the 16 March 2015 at 18:20.* [Registrant B] *was the lead nurse on duty. Resident A was placed in another resident's room for the night as it is stated that her own room was not ready. A body map was undertaken by nursing students [Colleague B] and [Witness 4].*
>
> *10.1.21 The body map evidenced that she had 3 pressures ulcers and multiple bruises on her body. Two grade 2 pressure ulcers on her left and right buttocks (measuring 6.5cm x 5cm and 3cm x2.5cm) and a grade 4 pressure ulcer to her left heel (measuring 3.5cm x 1.5cm). This was black in colour. Resident A's feet were elevated off the bed.*
>
> *10.1.47 On the 5 April 2015, the night nursing staff identified a pressure ulcer on Resident A's left ankle. In the patient records it stated that this was handed over to the day staff, but it is unclear what the day staff did with this information. There were no further comments or references in the patient records relating to this ankle ulceration and the wound evaluation chart and/or body mapping chart were not updated.*

The panel considered that it had no information before it that there was a duty to ensure that a body map was completed after 16 March 2015, as there is no clear policy as to how often the body map should be completed, and on which date the body map should be done.

The panel were also taken to Resident A's body map which does provide a handwritten date but is indecipherable.

The panel therefore found charge 4, with respect to this element, not proved.

D-8 Entries documenting that Resident A had good fluid and diet intake whilst at the home were inaccurate.

The panel had sight of Resident A's weekly food intake chart for the week commencing Monday 2 March 2015, which shows the period whilst she is in hospital, and shows entries being made again once she is discharged on 30 March 2015. The panel also had sight of Resident A's daily fluid balance chart, which is dated 12 May 2015 and provides entries for fluid intake. The panel was satisfied that there were consistent entries made for food intake and fluid intake on the days which Resident A was at the Home.

The panel considered that it has no evidence before it as to whether the entries which were made on the weekly food and fluid intake charts were inaccurate.

The panel therefore found charge 4, with respect to this element, not proved.

D-9 On the 28th April 2015, there were no records relating to pressure ulcers, body maps or skin inspections for Resident A

The panel was referred to Witness 3's police witness statement and noted the following:

'I couldn't see any repositioning charts which should have been in Resident A's room so I had to advise them to put a repositioning chart in her room and to turn her every 2 hours… I couldn't find any notes on when they had developed and I couldn't see any notes on skin inspections. The only recorded entry was on 18 March 2015 where red marks were indicated on the sacral area. I could not find any other paperwork about pressure ulcers, body maps or skin inspections'

The panel considered that if Witness 3 could not find the repositioning notes, it does not necessarily mean that these records did not exist and there may have been missing documents.

The panel had sight of Resident A's body maps, which appears to have the dates 28 February 2015, 18 March 2015 and 10 May 2015, and has some details filled in, and is followed by a wound evaluation form.

The panel therefore found charge 4, with respect to this element, not proved.

D-10 Body maps for Resident A were not completed on a weekly basis as advised by the TVN on the 1st May 2015.

The panel was referred to Witness 3's police witness statement and noted the following:

'I suggested that they complete a weekly body map and skin inspection of all residents. [Registrant B] *indicated that this is something she wanted to implement but felt that there was some resistance for this to be undertaken.'*

The panel noted that there are omissions in the paperwork from the Home, and it is therefore difficult for the panel to conclude that the body maps were not completed on a weekly basis. The panel considered that whilst it had been referred to some of Resident A's body maps, it does not have before it a consistent sequence of body maps.

The panel therefore found charge 4, with respect to this element, not proved.

D-11 Resident A's Temperature was not regularly monitored.

The panel had sight of the following from Witness 1's report:

> *10.1.69 The temperature checks that were requested by the TVN were not undertaken as recommended. The observation charts record inconsistencies and gaps.*

The panel was also referred to Ms 1's report, namely:

> *'The TPR (Temperature, Pulse and Respiration) Charts do not suggest that Resident A temperature was regularly monitored as recommended by the TVN; there are some sporadic entries within the Nursing evaluations as to the temperature being checked but not with any consistency.'*

The panel considered that it does not have any primary evidence in relation to this element of the charge, as it has not been provided with the TPR charts, nor the exact nature of the request from the TVN.

The panel therefore found charge 4, with respect to this element, not proved.

D-12 Did not ensure that resident A's MUST scores were recorded monthly whilst at the home.

The panel had sight of the report, in which she generally articulates what the recommendations are around MUST scores:

> *Malnutrition screening is advocated for those entering hospitals and care homes. A recommended method is the Malnutrition Screening Tool (MUST) which is based on a simple 3 steps of ;-*

- *A BMI below 18.5 scores 2 and a BMI of between 18.5 and 20 gives a score of 1*
- *unplanned weight loss in the past 3 months of more than 10% gives a score of 2 and an unplanned weight loss of 5-10% a score of 1*
- *if someone is acutely ill or has no intake for 5 or more days a score of 2 is given*

The scores are added together and depending on the score action should be taken

The panel also had sight of Witness 1's report, where she refers to Dr 1's report:

> *10.1.99.9 Dr 1 also stated that mid arm circumference is taken if weight is not possible and a measure of less than 23.5cm is consistent with a BMI of less than 20kg per metre squared which suggests someone who is malnourished. And thus, the MUST score throughout Resident A's time in Five Acres Nursing Home should have been 2 and was incorrectly recorded.*

The panel was not referred to any MUST scores for Resident A, and were not able to find any documentation relating to Resident A's MUST scores given the large volume of documentation before it. The panel concluded that it has no primary evidence before it in relation to this element of the charge.

The panel therefore found charge 4, with respect to this element, not proved.

D-13 Did not ensure that indication of food types or meal composition were consistently recorded in Resident A's food intake charts.

The panel was referred to Ms 2's report, namely the following:

> *'In expert document 1 (pg 6-20) weekly food intake charts for Five Acres Nursing home were shown. These charts showed a chart with 3 meals plus snacks which*

could have a cross put on them as regards the amount eaten. There was no indication of types of food or meal composition and no menus were provided to show items.'

The panel also had sight of Resident A's weekly food intake chart showing entries made for the week commencing 9 March 2015. The panel noted that the food intake charts before it shows consistent records and demonstrate the types of food and some indication of the amount of food taken. The panel also noted that there is nothing on the food intake chart which allows for anything other than a tick box to provide further information as to food type or meal composition. The panel considered that this is also stated by Dr 1 in her report as follows:

'The records are poor and give little detail and are simply tick lists. For example lunch has meat, vegetables and pudding with no descriptions. Thus there is no real information as to what was actually provided at mealtimes. Thus nutritional calculations are difficult but as will be seen in the calculation of the nutritional content of foods I have erred on the side of the home and been generous in what I have considered she ate both as regards the composition and also portion size.'

Therefore, the panel considered that food types or meal composition were consistently recorded insofar as the paperwork allowed.

The panel therefore found charge 4, with respect to this element, not proved.

D-14 Did not ensure that food intake or refusals of food were consistently recorded in the food intake charts

The panel took into account the following from Dr 1's report:

Weekly food intake charts for Five acres Nursing Home were found from 2-3-15 until 11-6-15 with periods from 2-3-15 until 15-3-15 when was in hospital. There

was a period of 74 days of records which were examined. Some days during the stay records were not available e.g. up to 30- 3-15. It was noted that care assistants had not documented intake or refusals in records (5 pg 6 of witness statement [Witness 6] *)).*

The panel also had sight of Witness 6's witness statement, which sets out:

'We would look at her notes and see that care assisants had been documenting that she was refusing to eat.'

The panel also took into account Resident A's food intake charts, which appears to have consistent records. The panel noted that entries can be seen indicating that Resident A was asleep. The panel also took into account that the food intake charts show entries stating that Resident A has refused food, which can be seen by the letter 'R' or words 'Refused all' recorded on the chart.

The panel therefore found charge 4, with respect to this element, not proved.

D-15 There are no records of Resident A taking three full meals in any one day.

The panel had sight of Resident A's weekly food charts and found numerous days on which Resident A was recorded as having consumed three meals, for example on 1 April 2015, 6 April 2015 and 8 April 2015.

The panel therefore found charge 4, with respect to this element, not proved.

D-16 On the 28/2/15 Resident A's daily record inaccurately shows that their food and fluid intake was good although there are no further records to indicate what food was taken AND Resident A's fluid chart shows as 300ml of intake for that day, which is inadequate.

The panel was referred to Dr 1's report and noted the following extract:

> *'There seemed little knowledge of nutrition in those writing the daily records as on 28-2-15 there is the comment diet/fluid intake good –there are no records for that day on food and the fluid records show a total of 775 ml intake of fluid which is inadequate.'*

The panel also had sight of Resident A's weekly food intake charts and noted that the first entry it has is from 2 March 2015. The panel noted that it does not have before it the daily record for 28 February 2015 and therefore does not have before it any primary evidence.

The panel therefore found charge 4, with respect to this element, not proved.

D-17 In 2015, did not ensure that Resident B's weight loss was reviewed.

The panel had sight of Resident B's MUST record chart, which shows a number of entries, namely for 9 September 2015, 21 September 2015, 5 October 2015 and 6 October 2015. The panel noted that the MUST record chart shows that Resident B's weight has been fluctuating, but the BMI score has remained consistent, and the MUST score has remained high.

The panel did not have evidence before it as to how the review of weight loss should be recorded. It however did have before it a clear set of MUST scores where weight was being recorded.

The panel also had sight of the following from Witness 1's report, which indicates that Resident B had been referred to the dietitian and reviewed in 2015:

> *16.13.2.2 Resident B's significant weight loss in 2015 was not referenced by Kevin Adams throughout 2015.*

> *10.2.36 On 3 June 2015 Resident B was seen by the dietitian due to his significant weight loss. Ensure supplement drinks were prescribed three times a day. Resident*

B's weight was requested fortnightly, with a review in September 2015. It was documented that his right buttock was bruised and sore.

The panel therefore found charge 4, with respect to this element, not proved.

D-18 Between January and May 2015, did not update Resident B's nutritional care plan on a monthly basis.

The panel had before it, Resident B's nutritional care plan which had been created on 1 March 2014, this was accompanied by an untitled care plan evaluation form. The panel noted that there was a handwritten update to the care plan in May 2015.

The panel also had before it Resident B's care plan evaluations, which shows handwritten entries made on 11 January 2015, 5 February 2015 and 6 April 2015. Despite one month missing, the panel considered that this was acceptable.

The panel also took into account that between 3 April 2015 and 11 May 2015, Mr. Adams was not at the Home.

The panel therefore found charge 4, with respect to this element, not proved.

D-19 In May 2015, the recommendations as provided by dietician/ SALT were updated in Resident B's care plan but their significant weight loss was not documented.

The panel had sight of Resident B's nutrition care plan, which was created on 1 March 2014, and shows a handwritten update dated May 2015 having been assessed by the speech and language therapist, which refers to a pureed diet and thickened fluids, but not significant weight loss. The panel also had sight of a record of members of the multidisciplinary team visits for Resident B, which shows an entry for 13 May 2015 by the

speech and language therapist, detailing the review during their visit, which correlates with the handwritten update on Resident B's nutrition care plan.

The panel noted Resident B's MUST nutrition screening tool, which shows entries made from February 2014 to May 2015, recording Resident B's present weight at the time of each entry, along with Resident B's BMI and MUST score.

The panel therefore found charge 4, with respect to this element, not proved.

D-20 Patient records suggested that Resident B had a good appetite which was incorrect.

The panel had sight of Resident B's daily notes, in particular an entry dated 26 May 2015 stating *'All personal care given. Meal given as charted. Eating & drinking well.'* The panel had sight of the corresponding food intake chart for Resident B, which shows an entry for 25 May 2015 indicating that Resident B had eaten three full meals that day.

The panel also took into account that it is recorded on Resident B's discharge form the Hospital that Resident B has an excellent appetite.

Taking all of this into account, the panel considered that the evidence shows that Resident B had a good appetite.

The panel therefore found charge 4, with respect to this element, not proved.

D-21 Resident B's diet chart was not always completed between January and August 2015.

The panel had sight of the following from Witness 1's report:

10.2.78.23 Diet charts were not always completed. The period of significant weight loss is when the diet charts did not appear to have been completed. The diet charts also suggest he was not always offered a pureed diet, even though this was prescribed by SALT, for instance on evening meals spaghetti hoops and chicken nuggets had been documented as having been given.

The panel also had sight of Resident B's weekly food intake charts from January 2015 to August 2015, which has largely been completed. It considered that although there are some occasional gaps present, overall, the recording of Resident B's food intake was adequate.

The panel therefore found charge 4, with respect to this element, not proved.

D-22 Resident B was not always offered a pureed diet even though this is the recommendation given by SALT.

The panel noted the following from Witness 1's report:

10.2.78.23 Diet charts were not always completed. The period of significant weight loss is when the diet charts did not appear to have been completed. The diet charts also suggest he was not always offered a pureed diet, even though this was prescribed by SALT, for instance on evening meals spaghetti hoops and chicken nuggets had been documented as having been given.

The panel had sight of Resident B's food intake chart and considered that there are references indicating that a pureed diet was often offered to Resident B. The panel also had sight of Resident B's new food chart dated from 17 August 2015, which demonstrates an awareness of the need for pureed food, provides several examples of pureed food which were offered to Resident B, and also indicates that Resident B needs to be fully assisted with his food.

The panel also noted that the entry which was made by the speech and language therapist in the multidisciplinary notes does not state that Resident B must have a pureed diet, but that there should be pureed options.

The panel therefore found charge 4, with respect to this element, not proved.

D-23 Nutritional care plan was not personalised or adapted to meet the changing needs of Resident B.

The panel had sight of the following from Witness 1's report:

> *10.2.78.19 The Nutritional care plan was not personalised or adapted to meet Resident B's changing needs. On admission, the documents stated that Resident B needed support with his food and drink due to his poor eyesight. However, this was not reflected in his care plans until August 2015*

The panel also had sight of Resident B's nutrition care plan which was created on 1 March 2024 and was updated on 5 February 2015, which sets out the following and does not agree with Witness 1's report:

> *'Resident B has a good appetite. He drinks well too.*
>
> *Resident B needs support to maintain nurturance [nutrition]*
>
> *Resident B is underweight. Reduced BMI*
>
> *Pureed diet/thickened fluids. Assessed by SLT May 2015'*

The panel also had sight of Resident B's new food charts dated from August 2015 to October 2015, which show that food that Resident B was offered was adapted and personalised for his pureed diet.

The panel therefore found charge 4, with respect to this element, not proved.

D-24 Between January and May 2015, Resident B's MUST score and weight monitoring was not completely on a monthly basis

The panel had sight of the following from Witness 1's report:

> *10.2.78.20 The Nutritional care plan was not updated monthly, and Resident B's MUST score, and weight monitoring was not carried out every month. It was not completed between January and May 2015 (during which time he had lost 5kg). [PRIVATE] BIA from MK Council stated within her police witness statement that she had been advised by staff that the weighing scales had been out of action for 2-3 months.*

The panel took into account Resident B's additional Nutrition Screening Tool MUST chart, which shows that there were no entries between January 2015 and May 2015. Therefore, there were no checks in February 2015 and March 2015 when Mr Adams was on duty as the clinical lead at the Home.

The panel therefore found charge 4, with respect to this element, proved.

D-25 Following Resident B's skin integrity breaking down between April and June 2015, a Respective Care plan was not implemented until September 2015.

The panel had sight of the following from Witness 1's report:

10.2.78.10 From April to June 2015 Resident B's skin integrity began to break down. The respective care plan was not in place until September 2015…

The panel also had sight of Resident B's skin integrity care plan, which was created on 8 February 2014 and shows a handwritten update on 23 June 2015, noting that Resident B had some moisture lesions. The panel noted that the care plan evaluation shows monthly entries from March 2015 to June 2015 indicating that the care plan was in place prior to September 2015.

The panel noted that Mr. Adams was not present at the Home from 3 April 2015 to 11 May 2015, after which he stepped down as clinical lead on 23 May 2015.

The panel therefore found charge 4, with respect to this element, not proved.

D-26 Resident C's nutritional care plan was not updated regularly.

The panel had sight of the following from Witness 1's report:

10.3.7 During his stay at Five Acres Nursing Home Resident C's weight and MUST score remained consistent, however his nutritional care plan was not updated regularly and did not make reference to food being needed to be cut up as he was his registered blind (his granddaughter in police witness statements was concerned that this was not being done). His son in the police witness statement suggested he had lost a lot of weight, however, the Nutritional Screening Tool evidenced that his weight was 58.8kg on admission and 60.2kg on discharge.

The panel also had sight of Resident C's nutrition care plan, which was created on 6 May 2013, and was last updated on 20 June 2014. The panel took into account that Resident C's weight and MUST scored remained consistent and therefore would not necessarily be updated. The panel was not able to establish any rationale as to why this is inadequate.

The panel therefore found charge 4, with respect to this element, not proved.

D-27 Resident F's nutritional plan was not personalised or regularly reviewed.

The panel noted that no date has been specified in the charge.

The panel had sight of the following from Witness 1's report:

> *10.5.30 A nutritional care plan was in place from April 2012 which was revised in October 2013. This plan included monthly weights, dietetic advice, oral hygiene, fluid balance charts and positional advice about an upright position on feeding.*
>
> *10.5.31 A PEG care plan (sites a and b) was developed in April 2012 and revised in October 2013. This plan included monthly weights, checking the PEG and rotating this, noting the risk around Resident F pulling at the tubing. This plan was not updated regularly in 2014. A new plan was developed in June and July 2015. This plan included the risk of aspiration and the need for her to sit upright when eating, cough as an indicator for aspiration and ensuring that her mouth was kept free from food debris.*

The panel also had sight of Resident F's nutrition care plan, which was initiated in April 2012 and was revised in October 2013. The panel noted that the plan appears to have been personalised and reviewed on 24 February 2014 and 12 January 2015.

The panel was also referred to Resident F's care plan, which is set out in a new format and dated 21 July 2015, which is after the date that Mr Adams stepped down as clinical lead.

The panel therefore found charge 4, with respect to this element, not proved.

D-28 Resident F's weight was not reviewed in March 2015

The panel was referred to the following from Witness 1's report:

> *10.5.35 Resident F had been seen by the dieticians in December 2014, they were pleased with her weight and had requested monthly weights. They recommended a further review in March 2015; however, this was not undertaken…*

The panel considered that it has not been referred to any primary evidence in relation to this charge.

The panel therefore found charge 4, with respect to this element, not proved.

D-29 No action plan was implemented following Resident H scoring a MUST score of 2 on the 3rd May 2015.

The panel was referred to the following from Witness 1's report:

> *10.7.26 Within the patient notes on 11 June 2015 it was documented by Kevin Adams that a weight recording on the 3 May 2015 evidenced that her MUST score was 2. Kevin Adams implemented a three-day food and fluid chart with a review of Resident H's Trazadone (anti-depressant). He felt that by reducing the Trazadone this would ensure that she was more awake and alert, which would improve her dietary intake. The GP agreed to decrease the Trazadone from the 12 June 2015. No further action plan was put in place in relation to Resident H's MUST score of 2. Twice daily supplements were only started on 13 August 2015.*

The panel considered that it has not been referred to any primary evidence in relation to this element of the charge.

The panel therefore found charge 4, with respect to this element, not proved.

Regarding charge 4 overall, the panel therefore find charge 4a not proved, except for element D-24. The panel find charge 4b not proved.

Charge 5

5) Failed to make, or ensure that, necessary and/ or timely referrals in relation to one or more Residents were made:

   a) As set out in Schedule E;

   b) Generally.

E-1 A referral to the Tissue Viability Nurse in relation to Resident A's Grade 4 left heel pressure sore and Grade 2 sacral area pressure sore was not made until the 23rd March 2015, having been identified on the 16th March 2015.

The panel had sight of Resident A's body map dated 16 March 2015 and noted that there seem to be handwritten comments indicating that the TVN was involved in the care of Resident A on 18 March 2015, as well as a note at the top of the body map stating *'TVN ref sent 23 March 2015'*.

The panel was also referred to Resident A's tissue viability referral form, which has a handwritten note on the top of the page *'added and scanned … 24 March 2015'*

The panel also took account of Ms 1's report, in particular the following:

> *4.131 I understand that a referral to the TVN was made on 23 March 2015*
>
> *4.123 I also note that the policy states that the Home manager must contact the TVN when a resident develops pressure damage so they can assess them and review the pressure relieving equipment. It goes on to state that 'staff should record the frequency of patients repositioning (turns) on the appropriate chart'*

The panel noted that as per Ms 1's report, the Home's policy states that it would have been the Home manager's responsibility, namely Colleague A, to make the referral. It further noted that it is not clear whether a week would be an unreasonable length of time for that referral to have been made.

The panel therefore found charge 5, with respect to this element, not proved.

E-2 A referral to SOVA (safeguarding and vulnerable adults) referral in relation to Resident A's Grade 4 left heel pressure sore and Grade 2 sacral area pressure sore was not made until the 22nd March 2015, more than 24-48 hours after they were identified on the 16th March 2015.

The panel had sight of the following from Ms 1's report:

> *4.122 An alert was sent by Five Acres Nursing Home to the Care Quality Commission on 18 March 2015 and a Safeguarding was raised on 22 March 2015*
>
> *4.120 Most localities have Multi-agency Safeguarding Policy in place which generally includes the reporting of Category 3, 4, and unstagable pressure ulcers*
>
> *4.123 I also note that the policy states that the Home manager must contact the TVN when a resident develops pressure damage so they can assess them and review the pressure relieving equipment. It goes on to state that 'staff should record the frequency of patients repositioning (turns) on the appropriate chart'*

The panel noted that as per Ms 1's report, it is generally expected to report safeguarding for grade 3 and 4 pressure ulcers, and that it would be the responsibility of the Home manager or the clinical lead, namely either Colleague A or Mr Adams, to do so.

The panel also had sight of Witness 1's report, in particular:

16.14.2.2 No SOVA was completed until the 22 March 2015. This was outside the SOVA reporting timelines, which should have been within 24-48 hours.

The panel considered that it could have been the responsibility of either Colleague A or Mr Adams, and that it has no evidence before it as to whether the 24–48-hour window is a recommendation, stated and passed down to be followed, or policy.

The panel therefore found charge 5, with respect to this element, not proved.

E-3 A referral to the Tissue Viability Nurse in relation to Resident A's grade 3 sacral ulcer on or around the 1st April 2015.

The panel had sight of the following from Ms 1's report:

4.123 I also note that the policy states that the Home manager must contact the TVN when a resident develops pressure damage so they can assess them and review the pressure relieving equipment. It goes on to state that 'staff should record the frequency of patients repositioning (turns) on the appropriate chart'

4.155 The nurse was clearly concerned with regards potential infection and yet only applied a simple contact layer to the wound as opposed to an antimicrobial or a dressing that would aid debridement of the devitalised tissue.

4.156 No re-referral was made to the TVN despite her concern

The panel also had sight of Resident A's daily notes, which has an entry dated 1 April 2015 referring to an infection and a swab being taken. The panel noted that Mr. Adams was not the nurse who had raised the concern regarding the infection. The panel also noted that it could have been the responsibility of Colleague A as per the Home's policy.

The panel therefore found charge 5, with respect to this element, not proved.

E-4 A referral to the Tissue Viability Nurse in relation to resident A's deteriorating, grade 4 wound was not made until the 24th April 2015 (even though noted as deteriorating on 17/4/15.

The panel had sight of Witness 3's witness statement, which sets out that on 24 April 2015, a referral was received from the Home about Resident A in relation to a grade 3 pressure ulcer on the right side of her lower back. The referral was made by Registrant B. On 28 April 2015, four days later, the TVN visited the Home.

The panel also had sight of Ms 1's report:

> *4.166 The GP records for 17 April 2015 note: 'telephone encounter re: wound. Not healing well. Swab results some bugs so antibiotics and see Erythromycin 250mg'*
>
> *4.167 Despite this clear deterioration in the wound, no re-referral to the TVN was made until 24 April 2015, i.e. not for another week.*
>
> *4.168 The entry for 24 April 2015 states that the sacral wound was 'necrotic, and sloughy, smelling'*

The panel considered that it has no primary evidence before it that it was unreasonable to wait until 24 April 2015, given that antibiotics were started on 17 April 2015. Further, the panel have no evidence that Mr. Adams was solely responsible to refer to the TVN any earlier than 24 April 2015.

The panel therefore found charge 5, with respect to this element, not proved.

E-5 A referral to the Dietician as recommended by the TVN in May 2015.

The panel had sight of Ms 1's report:

> *4.196 The TVN reviewed Resident A again on 13 May 2015 … and recommended a referral to the dietician and dietary supplementation*

The panel also had sight of Ms 2's report, in particular:

> *She advised to continue with the repositioning regimes and recommended a dietician referral. No record of any dietetic advice was found in the records*

The panel took into account the following from Witness 1's report:

> *10.1.83 I have no evidence that a dietetic referral was made.*

The panel considered that it has no primary evidence before it in respect of this element of the charge. Further, it appears that this was advice that did not necessarily need to be followed, and it is not clear whose responsibility it was to make any referral.

The panel therefore found charge 5, with respect to this element, not proved.

E-6 A referral to the Falls team before the 21st May 2015, Resident C having sustained falls on the 31st March, 6th, 16th, 26th April and 21st May 2015.

The panel had sight of Resident C's daily notes with a fall being noted on 30 March 2015, but no injuries, no concerns and an accident book was completed. A further entry made on 6 April 2015 which does not include any mention of a fall and is therefore contradictory to this element of the charge. An entry on 16 April 2015 details a fall in the morning and that observations were done; Resident C was sent to the hospital for an x-ray as they were unable to mobilise their hips. The doctor said that Resident C has not got a significant fracture and will be sent back to the Home. A fall was then documented on 21 May 2015,

following which an appointment was made with the GP/Primary Care Practitioner (PCP) and referral made to the Falls team.

The panel was of the view that it appears that appropriate welfare checks and actions were taken regarding Resident C. It does not have any evidence before it of a policy that indicates when a referral to the Falls team is required.

The panel therefore found charge 5, with respect to this element, not proved.

E-7 Resident H was not referred to the GP or Dietician

The panel was referred to Witness 1's report:

> *10.7.26 Within the patient notes on 11 June 2015 it was documented by Kevin Adams that a weight recording on the 3 May 2015 evidenced that her MUST score was 2. Kevin Adams implemented a three-day food and fluid chart with a review of Resident H's Trazadone (anti-depressant). He felt that by reducing the Trazadone this would ensure that she was more awake and alert, which would improve her dietary intake. The GP agreed to decrease the Trazadone from the 12 June 2015. No further action plan was put in place in relation to Resident H's MUST score of 2. Twice daily supplements were only started on 13 August 2015.*
>
> *10.7.32 Resident H was seen by dieticians on 9 July 2015. It was documented that Resident H had dropped 9kg in 3 months with variable oral intake. She was taking 50-75% of her breakfast and 75-100% of her lunch. They advised relooking at the evening meal and recommended that Resident H should be referred to SALT.*

The panel noted that Witness 1's report indicates that Resident H was seen by the dietitian on 9 July 2015, and discussions had taken place between Mr. Adams and the GP to help his dietary intake.

The panel considered that it has no primary evidence before it in respect of this element of the charge.

The panel therefore found charge 5, with respect to this element, not proved.

E-8 Following an assessment by the dietician on the 9th July 2015, Resident H was not referred to SALT for a swallow assessment until the 3rd September 2015.

The panel had sight of Witness 1's report:

> *10.7.32 Resident H was seen by dieticians on 9 July 2015. It was documented that Resident H had dropped 9kg in 3 months with variable oral intake. She was taking 50-75% of her breakfast and 75-100% of her lunch. They advised relooking at the evening meal and recommended that Resident H should be referred to SALT.*
>
> *10.7.33 This SALT referral for a swallow assessment did not happen until 3 September 2015.*

The panel also had sight of Resident H's daily notes, which shows an entry made on 9 July 2015 where Resident H was reviewed by a dietitian and prescribed supplements, but there is no mention of a recommendation for a referral to SALT. The panel noted that this contradicts this element of the charge. A further entry on 3 September 2015 details an urgent referral sent to SALT for swallowing assessment and contact made to dietitian for a further review following weight loss.

The panel therefore found charge 5, with respect to this element, not proved.

E-9 A referral to the Tissue Viability Nurse was not made following identification of Resident H's grade 2 pressure ulcer.

The panel had sight of Witness 1's report:

> *10.7.41 On 12 January 2015 it was documented that Resident H had a left ankle ulcer. No care plan, wound evaluation form or body map was put in place until 11 February 2015, by Kevin Adams. This care plan documented that Resident H had both left and right ulcerated/scabbed ankles. The left ankle was documented as a grade 2 pressure ulcer. There was no referral to the TVNs or SOVA completed at this time.*

The panel considered that it has no primary evidence before it in respect of this element of the charge.

The panel therefore found charge 5, with respect to this element, not proved.

Overall, the panel found charge 5 in its entirety not proved.

Charge 6

6) On the 25th March 2015, did not inform the Tissue Viability Nurse, when asked, that Resident A had other pressure sore areas that were not intact.

This charge is found proved.

In reaching its decision, the panel had sight of Witness 2's statement dated 4 August 2015:

> *On 25" March at approximately 15:30 hours I attended the home. I was shown to Resident A's room by the Nurse in charge Kevin ADAMS…ADAMS and I discussed whether there were any other pressure area issues and ADAMS confirmed they were intact.*

The panel also had sight of the following from Ms 1's report:

> *'4.147 I found a Wound Evaulation Chart dated 25 March 2015 which alludes to two areas of pressure damage over the sacral area as indicated as 'Pressure Sore B' in accordance with the Body Mapping*
>
> *4.148 The Evaulation suggests there is no wound (the 'wound bed' section has been crossed through) but that the skin is 'blistered and fragile' and 'Grade 2' with the damage measuring 6.5cm x 5cm and 3cm x 2.5cm'*

The panel also had sight of the following from Witness 1's report:

> *10.1.38 Resident A was seen by [Witness 2] TVN with Kevin Adams on the 25 March 2015. Summary: Hospital Acquired Category 3 pressure sore to heel 3.5cm x 4.5cm. This was black and necrotic. It was stated that Five Acres Nursing Home had completed a safeguarding alert.*

The panel noted that it has evidence that Mr. Adams and others at the Home were aware that there was an issue with Resident A's sacral area before the TVN (Witness 2) had visited. The panel considered that given that the TVN was already visiting Resident A on 25 March 2015, Mr. Adams should have asked Witness 2 to look at Resident A's sacral pressure ulcers as they were categorized at stage 2, and by accepted clinical definition, not an intact pressure area.

The panel heard oral evidence from Witness 2 in relation to the events which took place on 25 March 2015 during her visit to the Home. In response to panel questions, Witness 2 explained that whilst Mr. Adams spoke of Resident A's heel ulcer, there was no mention of anything else, despite her asking Mr. Adams if he had any other concerns about Resident A, and he responded 'no'. Witness 2 stated that she would have expected Mr. Adams to

alert her if Resident A had other pressure areas that were not intact and explained that it is unusual not to ask how to prevent the sacral ulcer progressing to a category three.

The panel was therefore of the view that Mr. Adams did not alert Witness 2 about Resident A's other pressure sore areas that were not intact.

The panel therefore find this charge proved.

Charge 7

7) Your action in charge 6 was dishonest in that you knew that Resident A had other pressure areas that were not intact and you did not disclose this to the Tissue Viability Nurse.

The panel find this charge NOT proved.

In considering this charge of dishonesty the panel applied the two-stage approach set out in the case of *Ivey v Genting Casinos (UK) Ltd (Crockfords Club) [2017] UKSC 67.*

The panel considered that Mr. Adams is of good character, and it is therefore less likely that he would have been dishonest.

The panel took into account that Mr. Adams' strongly denies dishonesty. It noted that included within a documented response to the NMC, Mr. Adams' stated 'dishonesty is a word never used against my name'.

The panel considered that it does not have any primary evidence before it as to Mr. Adams' state of mind at the point of this conversation on 25 March 2015. The panel has no note of what was discussed with Witness 2 on 25 March 2015. It was therefore of the view

that it does not have sufficient evidence before it to conclude that Mr Adams was intending to be dishonest, set out to be dishonest or was dishonest.

The panel therefore find this charge not proved.

Charge 8

8) Did not provide/ ensure that Resident A was provided with a relieving cushion for their chair on:

a) 19th March 2015 and/ or
b) 25th March 2015

The panel find this charge NOT proved.

The panel took into account the following from Ms 1's report:

> *'4.126 On 19 March 2015, was repositioned but spent all the time either on her right, on her back or sitting up in the chair between 04:15hrs and 22:15hrs – a total of 18 hours; she sat in the chair for 4 hours in total. There is no reference to a pressure reducing cushion being used'*

The panel noted the evidence from Witness 2 that at the time of her visit there was no pressure relief to Resident A's chair, however Resident A appeared to be in bed at that time, and the panel had no evidence before it that a pressure reducing cushion was not provided when required.

The panel therefore find this charge not proved.

Charge 9

9) Following Resident B's skin integrity breaking down between April-June 2015, a pressure relieving mattress was not put in place until the 26th June 2015.

The panel find this charge NOT proved.

The panel took into account the following from Witness 1's report:

> *10.2.78.10 From April to June 2015 Resident B's skin integrity began to break down. The respective care plan was not in place until September 2015. From evidence (Kevin Adams - care evaluation notes) it would also appear that a pressure relieving mattress was not in place until 26 June 2015 and a pressure relieving cushion was used from August 2015 (on the advice of the TVN).*

The panel took into account that it has no primary evidence before it in relation to this charge.

The panel therefore find this charge not proved.

Charge 10

10) On or before the 28th April 2015, did not ensure that suitable wound dressing materials were available at the home

The panel find this charge NOT proved.

The panel had sight of the following from Witness 3's statement:

> *There were two extensive wounds, one on the right and one on the left iliac (pelvic bone) which were 5cm by 6.6cm and 4cm by 3cm in size. The two wounds were full thickness skin loss indicating deep damage, grade 4 pressure ulceration. I took a*

photograph of the ulcer at this time. [Registrant B] *informed me that they did not have any large suitable dressings to be reapplied to the wound so I therefore reapplied a dressing from my own bag. I was concerned that they didn't have any dressings so I advised that the dressings should be ordered through ONPOS (online wholesale chemist who deliver direct) who can deliver the next day.*

…

redressed the pressure ulcers using my own dressings because the home still didn't have any, despite being requested the day before to order dressings in and have them delivered the next day.

The panel noted that it has no direct primary evidence before it to show that the dressings were not available, or when they ran out.

The panel noted that Mr Adams had a break in his service at the Home from Friday 3 April until Monday 11 May 2015, when he resumed employment there. Mr Adams resigned from the clinical lead role on 23 May 2015.

The panel therefore find this charge not proved.

Charge 11a

Practised inadequate medication administration in that you:

a) Pre-potted medication for Residents within the home;

The panel find this charge NOT proved.

The panel noted that it had heard oral evidence from Registrant B, who repeatedly indicated that pre-potting medication for Residents was only done if the Residents were asleep or has refused the medication and may take the medication at a later point.

The panel also noted that there is no Home policy before it which states that pre-potting is not acceptable.

The panel therefore find this charge not proved.

Charge 11b)

b) Failed to supervise student nurses during medication rounds;

The panel find this charge NOT proved.

The panel had sight of the following from Witness 4's statement:

I didn't do very much on my first day. Kevin ADAMS showed us both around and introduced us to the residents. He then told us what our general role would be which was to mainly shadow whichever nurse was on that shift and to assist them with medication, feeding of residents, occasional personal care of residents and wound management when necessary.

…

The majority of the time we did the medication rounds with [Registrant B] *but we did also do it with Kevin ADAMS*

The panel also had sight of Witness 4's NMC witness statement, in particular:

The failures in supervision relate to Mr Adams and the medication round. Whilst completing the medication rounds, he would tell me and … to complete what we could and give who we could the medications, and he would be 'hovering' and would be around to help if we had any problems. However, Mr Adams would normally go outside and smoke with the HCAs or would go to the office to speak

with [Colleague A], so would not actually be around to help. I cannot remember how many times this happened, however I think that it was most of the time.

The panel noted the following from Witness 6's NMC witness statement:

Soon after I began the placement at the Home, Mr Adams would begin doing the medication round with us but then ask us to carry on without him (he said he would catch up with us later). I believe that his goal was for Ms 1 and I to continue the round without him, although he never actually said this to me, however Ms 1 and I would always wait for him to turn up before actually administering medication. As students, we were not allowed to give medication without supervision, so we had to wait for him.

The panel considered that there was insufficient evidence before it to indicate that Mr. Adams' did not supervise the student nurses during the medication rounds.

The panel therefore find this charge not proved.

Charge 11c)

c) Failed to wake Residents in order for medications to be administered.

The panel find this charge NOT proved.

The panel had sight of Witness 6's statement:

I found that residents would be left in their beds until quite late, sometimes as late as 3pm in the afternoon without any medication or personal care given. I was told this was because if a resident is sleeping ii would be abuse if they were woken and it's not fair to wake them up.

The panel also had sight of Witness 4's statement:

If a resident was sleeping at the time of the medication, breakfast and personal care rounds I think they were left for an hour or so to continue sleeping and then I think they were woken up to be provided with what they needed, but I am not completely sure.

The panel was of the view that a duty has not been established in relation to this charge that residents needed to be woken up by a specific time in order for medications to be administered to residents, and that failing to wake the residents led to inadequate medication administration. It considered that it has no evidence before it as to how long residents were left sleeping, and it could be acceptable practice depending on the resident.

The panel therefore find this charge not proved.

Charge 12

12) Did not ensure that Resident C's Falls Risk Assessment was updated following falls.

The panel find this charge NOT proved.

The panel was not taken to any evidence to support this charge and therefore find it not proved.

The panel therefore find this charge not proved.

Charge 13

13) Between 1400h on 21/5/15 and 1400h on 22/5/15, following a fall by Resident C:

a) Failed to conduct/ ensure that observation checks were conducted at 30 minute intervals; and/ or

b) Did not record that/ ensure that any such checks were recorded.

The panel find this charge NOT proved.

The panel was referred to Witness 1's report and took into account the following:

> *10.3.23 On 21 May 2015 at around 14:00 Resident C had another fall. Checks should have been 4 hourly in accordance with the Falls Protocol. Kevin Adams requested that they were ½ hourly overnight. However, Resident C's observations were only undertaken six times between 17:00 on the 21 May 2015 and 14:00 on the 22 May 2015. P2P were called on the afternoon of the 22 May 2015, Resident C was noted to have a UTI.*

The panel noted that it has not been directed to any primary evidence in relation to this charge.

The panel therefore find this charge not proved.

Charge 14

14) Failed to provide or ensure that appropriate nursing care was provided to Resident D in that you did not take/ ensure that weekly blood sugar readings were taken.

The panel find this charge NOT proved.

The panel was referred to Resident D's notes. The panel had sight of Resident D's Diabetes Care Plan dated 1 October 2014, which provided the following instructions within the plan of care:

> *2. Commence on BM chart, with a handwritten note 'weekly'*

4. Regularly monitor blood sugars pre meal and 2200hrs/BD/Daily at 6am, with a handwritten note *'weekly as stable'*

7. Wear gloves when checking blood sugar

This is followed by Resident D's care plan evaluation, which provides monthly entries for the dates between January 2015 and July 2015, with the handwritten note *'Stable BM's – continue weekly checks'* written next to the date 14 July 2015.

Taking this into account, the panel was of the view that an appropriate regime had been put in place for monitoring Resident D's blood sugar readings.

The panel therefore find this charge not proved.

Charge 15

15) Between 8/8/14 and 2/1/15, failed to provide or ensure that an adequate standard of care was provided to Resident F in that you did not:

a) Take/ ensure that the Waterlow Assessment was conducted on a monthly basis; and/ or

b) Did not record/ ensure that such assessments were recorded.

The panel find this charge NOT proved.

The panel had sight of the following from Witness 1's report:

10.5.28 Resident F was at high risk of pressure sores. Resident F's Waterlow assessment should have been recorded monthly, however, these reviews were not always undertaken between 2014 and 2015 (8 August 2014 - 2 January 2015). In January 2015 her Waterlow assessment was 18 (high risk) and whilst she had a

pressure relieving mattress (which was not inspected daily as per documented records), she needed a new pressure relieving cushion. This was identified as being faulty by the CCG on 16 June 2015. It is unclear how long this cushion had been ineffective.

The panel noted that it has not been directed to any primary evidence in relation to this charge.

The panel therefore find this charge, in its entirety, not proved.

Charge 16

16) Failed to provide/ ensure that an adequate standard of nursing care was provided to Resident G in that no care plans and/ or risk assessments were in place in respect of the following:

a) Pressure ulcers;
b) Palliative care;
c) Aspiration Pneumonia;
d) Nutrition;
e) Dysphagia; and
f) CVA and contractures.

The panel find this charge NOT proved.

The panel was referred to Resident G's care plans. It had sight of care plans for Resident G dated 3 April 2015 in relation to pressure ulcers, as well as some care plan evaluation sheets.

The panel noted that whilst it does not have before it any risk assessments, it considered that there are omissions in the documentation presented to it and could not therefore conclude that a missing record necessarily meant that something had not been done.

The panel therefore find this charge, in its entirety, not proved.

Charge 17

17) Performed a manual evacuation procedure on Resident F when it was not clinically justified or appropriate to do so.

The panel find this charge proved

The panel noted the following from Witness 1's report:

> *10.5.131 June 2015: Resident F was constipated. A rectal examination was undertaken twice and a manual evacuation performed. This was witnessed by two student nurses.*
>
> *16.14.6.6 It was documented that Kevin Adams carried out a manual evacuation procedure. There is no evidence that Resident F had difficulties passing stool (non-reflex bowel) and it is unclear why this method was chosen rather than allowing Resident F to defecate naturally. Manual evacuation should only be used as a last resort when an individual cannot pass stool naturally. The student nurses who witnessed this incident were concerned about the procedure used by Kevin Adams.*

The panel had sight of the following from Witness 6's statement:

> *Kevin ADAMS came to us and told us that he was going to conduct a 'manual evacuation' on a resident. I can't remember the name of the female but she was the*

only resident at the time that was being peg fed and her bedroom was on the first floor. We went to her room with him and already in the room was one of the female care assistants. I can't remember her name. I didn't know what a 'manual evacuation' was so I didn't know what he was about to do. Kevin ADAMS put some gloves on. He told us that the female was constipated and laxatives hadn't worked. I remember Ms 1 being uncomfortable with this and she said to him that she had seen the procedure before but it was done by a doctor. Ms 1 asked him why he hadn't got a doctor out to do it. The female was lying on her side already. [PRIVATE]. The female was distressed and her face was red. The care assistant was holding onto her arms to keep her still. Through this procedure he managed to remove quite a bit of faeces.

…

I was shocked by the procedure and, couldn't believe what I had seen but I had never heard of it before. Ms 1 was not happy that Kevin ADAMS had carried out the procedure. We spoke to a lady … at the university about it to raise our concern. This was done verbally… told us that if we weren't happy with something in the future to ask the nurses to show us the policies and procedures around the procedure prior to being party to it.

The panel noted that Witness 5 also provided an account of this event in her oral evidence, which was consistent with her statement:

There was also a female, whose name I can't remember, who I had real concerns about. On one occasion she was severely constipated. She hadn't had any bowel movements for a while and Kevin ADAMS had tried giving her an enema but it would keep slipping out of her anus. I then witnesses Kevin ADAMS conduct a 'manual evacuation'. [PRIVATE]. The female resident was in her room on her bed. In the room was Kevin ADAMS, a health care assistant (I can't remember who it was), [PRIVATE] and I. Kevin ADAMS said to us something along the lines of "I

KNOW I SHOULD DO THIS, IT'S NOT BEST PRACTICE" before performing the procedure. The female resident was lying on her side with her legs slightly bent. The health care assistant held her arms whilst he did it. [PRIVATE]. It wasn't nice for the resident. Afterwards the health care assistant cleaned the female up and Kevin ADAMS tried to explain to us why he did it. He said to us that it's not something that should be done but because of the state the female was in he did it. As far as I am aware, if a nurse is not achieving results using the proper techniques and procedures, medical advice should be sought from a GP or hospital.

…

During my placement I spoke to the university on a couple of occasions raising my concerns.

The panel was of the view, based on the evidence before it, that Mr Adams performed a manual evacuation procedure on Resident F when it was not clinically justified or appropriate to do so. The panel considered that the clinical justification in these circumstances would be extremely rare, and even if justified, would have had to be done by someone that had been properly trained in the procedure.

The panel therefore find this charge proved.

Charge 18a

18) Failed to ensure that Resident A received an adequate standard of care, in that you:

a) On the 20/3/15, did not reposition/ ensure that Resident A was repositioned every two hours between 1400h and 2100h.

The panel find this charge NOT proved.

The panel noted that Mr Adams was not on duty on 20 March 2015, and could not have therefore been directly or indirectly responsible for ensuring that Resident A was repositioned every two hours.

The panel therefore find this charge not proved.

Charge 18b

b) On the 21/3/15, did not ensure that Resident A was repositioned every two hours;

The panel find this charge proved.

The panel noted that Mr Adams was on duty on 21 March 2015, and therefore was the nurse directly caring for Resident A.

The panel had sight of Resident A's skin integrity/repositioning chart, which shows that repositioning was carried out at wider intervals than recommended, at times more than three hours.

The panel therefore find this charge proved.

Charge 18c

c) On the 23/3/15, allowed the use of a faulty mattress in respect of Resident A;

The panel find this charge NOT proved.

The panel had sight of Witness 2's statement, which provided the following:

'I checked the mattress and the alarm light was on (indicating a fault with the equipment). I addressed this with ADAMS and was told it would be replaced the same day.'

The panel also had sight of the following from Ms 1's report:

4.132 A TVN [Witness 2] *reviewed Resident A on 25 March 2015*
4.133 She noted that the mattress upon which Resident A was being nursed had a fault light displayed and that the mattress was going to be changed that day
4.134 Most modern dynamic air mattresses have both a fault light and an audible alarm that sounds if there is a fault with the mattress; there are nor references to the light or alarm sounding on prior to the TVN attending on 25 March 2015; it is therefore unclear exactly how long the mattress had been faulty… As the audible alarm was not sounding, I can only conclude that it had been muted. Without knowing exactly which mattress she had, I am not able to establish whether this particular model would over-ride the 'mute' after a period of time or whether, once muted, it stayed muted

The panel considered that there was no evidence provided by either Witness 2 or Ms 1 which established how long the alarm had been active prior to it being noted by Witness 2. The panel further noted that Ms 1's report was not based on direct observation and was an elaboration of the statement provided by Witness 2. The panel noted that Ms 1 was not aware of the bed model in use and could not therefore reliably comment on the type of alarm or mute over-ride. The panel was not satisfied that Mr Adams had therefore allowed the use of a faulty mattress.

The panel therefore find this charge not proved.

Charge 18d

d) On the 8/4/15, was not repositioned at all between 0720h and 2100h;

The panel find this charge NOT proved.

The panel noted that Mr Adams was not employed at the Home from Friday 3 April until Monday 11 May 2015, and was therefore not present or on duty on 8 April 2015.

The panel therefore find this charge not proved.

Charge 18e

e) Did not ensure that Resident A's sacral wound dressing was changed every two days on or around the 13/5/15;

The panel find this charge NOT proved.

The panel took into account that Mr Adams was not employed at the Home from Friday 3 April 2015 until Monday 11 May 2015 when he resumed employment there. It noted that on 16 May 2015, an updated care plan was completed by Mr Adams and Wound Evaluation Forms were also recommenced by Mr Adams.

The panel further noted that the TVN review on 29 April 2015 recommended dressing changes to the sacral area *'when evidence of exudate/? daily – every two days'* this was not revised at the subsequent TVN visit. Given Mr Adams' absence during early May 2015, and the revised care plans, Wound Evaluation Forms and the flexibility of the TVN recommendation, the panel was not satisfied that Mr Adams had failed to dress Resident A's sacral wound as recommended.

The panel therefore find this charge not proved.

Charge 18f

The panel find this charge NOT proved.

f) Did not ensure that Resident A was provided with the minimum of 1500mls of fluids on a daily basis.

The panel had sight of the following from Dr 1's report:

> *An adult of age needs a minimum of 1500ml and on only one day (17-4-15) during the period from 28-2-15 until 11-6-15 do the records show an intake of this level. Some individuals do manage with less fluid and the often used figure is 30ml per kg body weight so for looking at her post mortem weight of 33kg this would be a minimum of 990mls. On 21 days the fluid intake was 1000mls to 1500mls. The remainder of the time the fluid recorded was extremely low at 500ml or less. This shows that on most days did not have adequate fluid and would have been chronically dehydrated which would have contributed to her mental confusion, dry skin and poor wound healing as well as constipation and UTIs*

The panel therefore considered that it had not seen primary evidence that 1500mls of fluid daily was a requirement.

The panel had sight of Resident A's daily fluid balance charts. It noted that the shortcomings of the charts did not allow coding for fluids that were offered and refused. The panel also considered that it may not always be possible to encourage residents and ensure that they accept fluids. The panel in addition had sight of daily fluid balance charts which showed regular entries, including one dated 29 March 2015.

Overall, the panel was of the view that it does not have before it sufficient evidence to support this charge and therefore find it not proved.

Charge 18g

g) Between the 1/3/15 and 11/6/15, did not ensure that Resident A was provided with the Ensure Plus supplements on a daily basis.

The panel find this charge NOT proved.

The panel had sight of Dr 1's report, in which she states that no reference to Ensure Plus being recorded on medication sheets can be seen:

> ***Prescribable supplements***
>
> *The GP had prescribed 2 Ensure plus supplements per day (220 ml per supplement produced by Abbott laboratories and which provide 1.5kcal per ml) which would have provided 660 calories per day. These do not seem to have been regularly given.*

The panel also had sight of Resident A's medication administration record dated 13 April 2015, in which it can be clearly seen that Ensure had not been prescribed at that point. A further medication administration record dated 11 May 2015 also shows that Ensure has not been prescribed. A final medication administration record dated 8 June 2015 shows that Ensure Plus was prescribed and administered.

Taking all of this into account whilst bearing in mind the period of time between Friday 3 April 2015 until Monday 11 May 2015 where Mr Adams was not at the Home, the panel was of the view that it has insufficient evidence before it to find this charge proved.

Overall, the panel found charge 18, except from charge 18b, not proved.

Charge 19

19) In or around May 2015, on more than one occasion, did not offer/ ensure that Resident A was offered an alternative breakfast following their refusal of the meal offered.

The panel find this charge NOT proved.

The panel had sight of the following from Dr 1's report:

> *Breakfast*
>
> *As regards breakfast she was noted to be asleep on 31st March, 2nd, 3rd, 4th, 5th, 7th 13th, 26th, April, 4th, 9th, 11th, 17th May a total of 12 days. No alternatives were recorded.*
>
> *On the 12th, 17th, 19th, 20th, 23rd, 27th, April, 2nd, 6th, May, 2nd, 3rd, 4th, 5th, 8th, 9th, and 11th May a total of 16 days breakfast was refused –on these days there is no evidence of any alternative being offered and thus ate nothing for breakfast on 28 days of her 74 days stay when records were available due to refusal or she was sleeping.*

The panel noted that on the dates mentioned in the above extract, Mr Adams was not employed and therefore not on duty at the Home.

The panel therefore find this charge not proved.

Charge 20

20) Between the 31/3/15 and 17/5/15, did not ensure that Resident A was woken from their sleep in order to eat their meals on more than one occasion

The panel find this charge NOT proved.

The panel noted that Mr Adams was not on duty at the Home for the majority of the time between 31 March 2015 and 17 May 2015. It further noted from the evidence before it that on 1 April 2015 Mr Adams was on duty and Resident A had taken their food, on 11 April

2015 Resident A is marked as asleep, on 12, 14 and 15 April 2015 Resident A had taken their food and on 17 April 2015 Resident A was marked as asleep.

The panel considered that in this setting there may be occasions where it was appropriate to allow a resident to sleep, but accepted that in these circumstances, food should be offered later. Given the limitations of the food charts and poor record keeping in general, the panel was not satisfied that when the resident was asleep, alternatives were not subsequently offered.

The panel therefore find this charge not proved.

Charge 21

21) Did not record whether alternative meals were offered to Resident A after waking from their sleep or ensure that such information was recorded.

The panel find this charge NOT proved.

Given the panel's findings and evidence reviewed in respect of charge 20, the panel find this charge not proved

Charge 22

22) Failed to ensure that food and fluid intake records were completed to an adequate standard in respect of one or more residents.

The panel find this charge NOT proved.

The panel noted that this charge does not refer to any specific date.

The panel considered that it has before it numerous food charts that had been completed regularly. It was of the view that there was not a sufficient definition of the word ‘adequate’ and therefore found this charge not proved.

Charge 23

23) Did not ensure that Resident A’s sacral ulcer dressing was changed on a regular basis.

The panel find this charge NOT proved.

The panel was referred to the following from Ms 1’s report:

> *4.171 The dressing was apparently being changed daily now although again there is no reference to what dressing was being applied*

The panel noted that this charge does not refer to any specific date and does not have before it a sufficient definition of ‘regular basis’. In light of the general nature of this charge, and the above extract, the panel found this charge not proved.

Charge 24

24) Between 1st and 11th June 2015, you failed to:

a) identify and/ or escalate Resident A’s deterioration; Recognise that Resident A’s left leg had become gangrenous.

The panel find this charge NOT proved.

The panel had sight of the following from Witness 6’s statement:

…After she [Resident A] *began to deteriorate I noticed that there was always be a strong smell of gangrene coming from her room. It was an offensive smell and I know it to be the smell of gangrene because I have dealt with it before. Kevin ADAMS was aware of the gangrene smell and was aware that it her was leg that giving off the smell. As far as I was aware leg had been bandaged up. I didn't see the leg myself due to the bandaging. I am not sure what was done about the fact her leg was going gangrenous. I believe a doctor did come in at some point to see Resident A. Within about a week of Resident A deteriorating she passed away.*

The panel noted the following from Dr 1's report:

'It is my professional opinion, that Five Acres Nursing Home did not provide the expected standard of care for the late Resident A, which contributed significantly to her demise. As an organisation, the nursing home was in gross breach of their duty towards a vulnerable and frail patient…'

The panel also had sight of the following from Witness 1's report:

16.11 External Agencies' View of Kevin Adams:

16.11.2 … , Registered Clinician with Patients to People (P2P), stated in her police statement that on recognising that Resident A had gangrene Kevin Adams shrugged his shoulders.

The panel noted that Mr Adams had stepped down from the clinical lead role at the Home on 23 May 2015. The panel considered that it does not have before it sufficient evidence on whether Mr Adams was responsible to identify and/ or escalate Resident A's deterioration and recognise that Resident A's left leg had become gangrenous. Additionally, the panel noted that a doctor and a nurse practitioner had both come to

examine Resident A, indicating that the deterioration of Resident A had already been identified and escalated.

Therefore, the panel find this charge not proved.

Charge 25

25) On the 27/8/14 you made/ sent an inappropriate comment, remark or words via message set out to the effect below:

Name	Message
KA	“Resident got broken down heel nearly open???? Bloody nurses here are shocking”
Colleague 1	“WHAT!!!”
KA	“Yep thankfully it’s been spotted and should b ok”
Colleague 1	“Has it been kept in house or are we going to get a sova again, don’t want another fore sore to heal”
KA	“In house but gotta lie”
Colleague 1	“Thanks for sorting it AGAIN mate”
KA	“Last Time!”

The panel find this charge proved.

The panel had sight of the corresponding telephone downloads and was of the view that the messages *‘Bloody nurses here are shocking’* and *‘In house but gotta lie’* made by Mr Adams were inappropriate.

The panel therefore find this charge proved.

Charge 26

26) On the 2/9/14 you made/ sent an:

a) Inappropriate and/ or

b) Discriminatory and/ or

c) Offensive

Remark or words to the effect set out below:

Name	Message
KA	"The daughter said to me when she came to view her mum had lost loads of weight fuck knows how big she was before" "Expense fuck that [PRIVATE] wont do it for one fat cunt"
KA	"That's not to say I wouldn't work anywhere else with you trouble shooting just no longer five acres it's the place and the workers all fucking self centered wankers."

The panel find this charge proved in relation to a) and c)

The panel had sight of the corresponding telephone downloads and was of the view that the entirety of the above messages made by Mr Adams were inappropriate and offensive. The panel noted that weight and size is not a protected characteristic as per the Equality Act 2010 and therefore did not find Mr Adams' messages to be discriminatory.

The panel therefore found this charge in relation to a) and c) proved and not proved in relation to b).

Charge 27

27) On the 2/9/14 you made/ sent an:

a) Inappropriate and/ or

b) Discriminatory and/ or

c) Offensive and/ or

d) Racist remark or words to the effect set out below:

Name	Message
KA	"[PRIVATE] is there tomorrow… but not but lol… great I'm keeping away or ill but him"
Colleague 1	"What up the arse!!"
KA	"Yeah"
Colleague 1	"ahahahah"
KA	"once you go black you won't get your belongings back!!"

The panel find this charge proved in relation to a) and c).

The panel had sight of the corresponding telephone downloads and noted that the wording on the Extraction Report matches the wording in the messages set out above. The panel was of the view that the above messages made by Mr Adams were offensive and inappropriate but did not conclude that they were discriminatory or racist as it was not entirely clear about the interpretation of the last message by Mr Adams quoted above.

The panel therefore find this charged proved in relation to a) and c) and not proved in relation to b) and d).

Charge 28

28) On the 21/10/14 you made/sent an:

a) Inappropriate and/ or

b) Discriminatory and/ or
c) Offensive and/ or
d) Racist remark or words to the effect set out below:

"Fat blackie said she phoned as was told that she wasn't on the rota tonight by a carer."

The panel find this charge proved in in its entirety.

The panel had sight of the corresponding telephone downloads and noted that the wording on the Extraction Report matches the wording in the messages set out above. The panel was of the view that the above messages sent by Mr Adams were offensive, inappropriate, racist and discriminatory, given that race is one of the protected characteristics.

Charge 29

29) Between September 2014 and July 2015 you made/sent an:
a) Inappropriate and/ or
b) Discriminatory and/ or
c) Offensive and/ or
d) Racist remark or words, about a colleague or resident, on more than one occasion.

The panel find this charge proved in its entirety.

In reaching its decision, the panel took into account its findings in relation to charge 28. The panel noted that the date of 21 October 2014 falls in dates covered in this charge, namely between September 2014 and July 2015.

The panel had sight of the corresponding telephone downloads in the Extraction Report and took into account the following message dated 26 September 2014:

Tip top, don't take advice from dyslexics !!

The panel considered this to be of a discriminatory nature, as dyslexia is a disability and therefore is covered by one of the protected characteristics.

The panel therefore find this charge proved in its entirety.

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 Mr Adams' 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, Mr Adams' 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.'

Ms Norman 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.

Ms Norman identified the specific, relevant standards, which she submitted, were where Mr Adams' actions amounted to misconduct.

Submissions on impairment

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

Ms Norman submitted that there is current impairment on the basis of both public protection and public interest grounds. She invited the panel to note that there has been very little and almost no engagement by Mr Adams with this process, aside from his denials at the outset.

On that basis, Ms Norman invited the panel to find that Mr Adams has displayed no insight and consequently can have made no remediation, or at least none that will be evident to the panel. She referred the panel to Mr Adams' handwritten response included within the NMC Regulatory concerns response form, which was signed and dated on 30 June 2019. Ms Norman submitted that the handwritten note provides nothing more than a flat denial from Mr Adams, for example *'I have never conducted manual evacuation'*. She submitted that the panel found in its reasons that Mr Adams did conduct a manual evacuation,

having heard evidence from witnesses who reported with extreme disgust seeing that happen.

Ms Norman informed the panel that Mr Adams' additionally sent some emails to the NMC prior to the charges being brought against him, at the NMC screening stage, the first of those dated 31 June 2015. Ms Norman submitted that what comes across in this email is a certain amount of blame for other people, where he states, *'Had I not have left and then returned I'm confident most of the findings and concerns would not have been there to cause concern.'* Mr Adams goes on to say the following in relation to the suggestion of suspension *'Suspending my registration I feel will deny me the chance to move forward and access a work environment that can help and support me. I worked very hard through university and twice as hard to build a good reputation with colleagues, doctors, families and MDT workers.'* Ms Norman submitted that there is no insight from Mr Adams in his email into the impact of his failings on the patients or the other staff.

Ms Norman referred the panel to a further email from Mr Adams dated 30 April 2016, in which he states that he has completed a pressure area care and wound care course:

> *to date I have completed pressure area care and wound care course, provided by the tissue viability service Northampton. I have just successfully completed a IHEC course provided by [PRIVATE] CCG, Northampton. Part of the course also looks at tissue viability in great depth, prevention and management. In May I have been accepted on an advanced tissue viability course run by smith and nephew, a whole day course.*

Ms Norman submitted that whilst Mr Adams claims to have completed a pressure area care and wound care course, he does not provide any information as to what he learnt from the course, only that it has been done. She further submitted that it does not look like there is any PDF attachment to the email, which suggests that the NMC is not in receipt of the corresponding certificate, and this does not appear in the NMC bundle either. Within the same email, Mr Adams seeks to blame the Home manager, that he has been singled

out to protect others, that he has no knowledge of the pressure sores and speaks of the impact of the restrictions on himself and his family and friends:

> *The home manager had responded to the NMC confirming that I had stepped down from the position, email dated 5/6/15 following the CQC inspection. The home manager then indicates that I was still in post when the pressure sores were discovered in a later dated email, this contradicts any credibility of his facts sent to the NMC. Please take the time to identify and read these emails.*
>
> *The point I'm trying to make is I feel that I have been singled out by the home manager to put me in the spot light and protect others (nurses at five acres).*
>
> *…*
>
> *As I have previously stated I had no knowledge of the pressure sores and when I did acted as I see appropriate at that time, also be mindful another nurse knew before me and done nothing.*
>
> *…*
>
> *… the restrictions on my practise is having an impact on [PRIVATE]. The impact is felt at home and within my family/ friends network. I'm left wondering whether nursing is a career I'm wishing to continue perusing.'*

Ms Norman submitted that there is nothing within any of these three documents to demonstrate that Mr Adams has any insight at all into the impact of the failings at the Home, on the residents themselves or on other staff. She submitted that on this basis, she invites the panel to find that even within the limited engagement Mr Adams had within those three emails, the panel may find that it cannot assess any insight or remediation when there is simply no evidence of any at all. Ms Norman further submitted that these were failings across multiple areas, involving not only record keeping failures, but also failure in caregiving. She submitted that these also include attitudinal failings, which have been recognised as notoriously difficult to remediate.

Ms Norman submitted that the issue of the manual evacuation is shocking, and the messages between Mr Adams and Colleague A display a level of contempt for both staff and patients. Ms Norman informed the panel that the Coroner who conducted the inquest for Resident A had sight of these messages and commented that the Home manager and Mr Adams accepted that there had been failings and that he found that the text messages he was shown were *'sickening'.*

Ms Norman submitted that this goes to both the public protection and also public interest concerns in this case. She invited the panel to consider how an ordinary person in full knowledge of these facts feel about such a person returning to nursing practise, and to also consider that such a person would regard those messages as sickening in respect of somebody who took care of the frail and elderly.

Ms Norman submitted that in relation to public interest, it is known from the Coroner's reports and their conclusion that Resident A on a balance of probability died of neglect and stated, *'…in sort of 14 years of sitting here as Coroner, this is the first occasion on which I have felt it appropriate to return a free standing conclusion of neglect but I have no hesitation to do so on this occasion.'*

Ms Norman submitted that whilst Mr Adams is not solely or entirely responsible for those failings at the Home, he is responsible for his part in those failings, and this was not a completely isolated incident, and his own failings cannot be completely isolated from that bigger picture of the failings of the Home, which failed its residents to a shocking degree. She submitted that the panel are aware, in relation to Resident B's inquest that the authorities were aware of the concerns relating to Resident B's care and were aware that his care as delivered was not in his best interest.

Ms Norman submitted that it is completely a matter for this panel to assess the extent to which a public interest finding on impairment is necessary but invited the panel to consider these passages from the Coroner's report in doing so. Ms Norman on that basis invited the panel to find that these is current impairment on both the public interest and public protection grounds.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *General Medical Council v Meadow* [2007] QB 462 (Admin) and *R (Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin).*

The Legal Assessor advised the panel to rely on its own processes and not any comments from the Coroner's investigation and reports. The Legal Assessor also advised the panel to consider separately each charge found proved when assessing misconduct.

The panel has arrived at its own conclusions in relation to misconduct exclusively on the basis of the facts found proved. It notes that none of the allegations against Mr Adams suggest any causative link between his conduct and the outcomes for Resident A and Resident B. Whilst the panel has considered the remarks of the Coroner, it has arrived at its own conclusions based on its factual enquiry which differs in scope nature and purpose to the enquiry conducted by the Coroner.

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 Mr Adams' actions did fall significantly short of the standards expected of a registered nurse, and that Mr Adams' actions amounted to a breach of the Code. Specifically:

> *1 Treat people as individuals and uphold their dignity*
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

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

To achieve this, you must:

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

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

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 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:
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

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with … integrity at all times, treating people fairly and without discrimination, …
20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way
20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

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 that Mr Adams' actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct:

Charge 1a (in relation to subsection 6 of schedule A in relation to Resident B)

The panel considered that failing to review a falls care plans on a monthly basis would have an impact on the care for Resident B, but taken on its own, although it was poor practice, does not meet the serious threshold to amount to misconduct.

Charge 3 (in relation to subsections 7, 8, 10, 12, 15, 17, 19, 20, 21, 22, 37 and 38 on Schedule C)

The panel noted that the evaluation of care plans is important for the ongoing care of residents, and this was not done on multiple occasions, in a variety of different areas. The panel considered that this was not a single one-off incident and consists of repeated incidents which establishes a pattern. The panel was therefore of the view that Mr Adams' conduct in relation to this charge was a serious departure from the standards expected of a registered nurse and amounted to misconduct.

Charge 4a (in relation to subsection 24 on Schedule D)

The panel considered that failing to complete Resident B's MUST score and weight monitoring on a monthly basis would have an impact on the care for Resident B, but taken on its own, although poor practice, does not meet the serious threshold to amount to misconduct.

Charge 6

The panel was of the view that Mr Adams' conduct in relation to this charge constitutes misconduct due to the risk of harm posed to Resident A by their pressure sores further developing. It considered that by not addressing the risk to Resident A, namely the risk of further pressure damage, Mr Adams' actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 17

The panel considered that manual evacuation is a very invasive procedure that Mr Adams' was not trained to carry out and was of the view that it was not appropriate or clinically justified for him to do so. The panel noted that Mr Adams' actions caused actual harm to the resident in terms of distress and pain, and carried a risk of serious physical harm, as well as actual harm to the resident's dignity. The panel was therefore of the view that Mr Adams' actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 18b

The panel was of the view that there was a significant risk of harm from not repositioning Resident A due to the existing pressure damage. It considered that Mr Adams was aware that Resident A was extremely unwell, had other pressure sores, was nutritionally compromised, frail and entirely dependent on staff. The panel was therefore of the view, taking into account the context of Resident A's condition, that failing to reposition Resident A falls seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charges 25, 26a, 26c, 27a, 27c, 28 and 29

The panel noted its findings that the messages sent by Mr Adams were inappropriate, offensive, discriminatory and racist and that his actions in doing so breach the fundamental tenets of the nursing profession. The panel was of the view that this is extremely serious, and that Mr Adams' behaviour as exhibited by his messages on multiple occasions was grossly unprofessional and has no place within professional communication. The panel was therefore of the view that Mr Adams' conduct falls seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

The panel also found that the messages sent by Mr Adams were deplorable in the way he spoke about colleagues and residents and would bring the nursing profession into disrepute.

Decision and reasons on impairment

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

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

The panel also had sight of the NMC Guidance on Impairment, Reference DMA-1, Last Updated 27 February 2024.

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

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

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

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

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

The panel was of the view that all three limbs a-c of the test are engaged. The panel finds that patients were put at risk of physical harm and caused actual emotional harm as a result of Mr Adam’s misconduct and underlying this was a lack of care and compassion for the residents at the Home. Mr Adams’ misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that it has no up-to-date information from Mr Adams and therefore no documentary evidence in relation to any steps he has taken to demonstrate an understanding of the regulatory concerns against him, why what he did was wrong and how this impacted negatively on patients’ safety and the reputation of the nursing profession.

The panel was satisfied that some of the clinical misconduct in this case is capable of being addressed. However, the panel was also of the view that some of the misconduct was more serious and more difficult to address, for example the attitudinal issues and racist and discriminatory nature of the emails sent by Mr Adams. The panel carefully considered the evidence before it in determining whether or not Mr Adams has taken steps to strengthen his nursing practice. The panel noted that whilst Mr Adams has made reference to having completed a course in wound care, the panel has no evidence before it of the course having been completed, nor that Mr Adams has taken steps to remediate the concerns around wound care in practice, nor any of his other misconduct. The panel took into account that Mr Adams has not engaged with the NMC since 2016 and showed very limited insight in his responses. The panel considered that it has nothing before it as to how Mr Adams has reflected and learned as he has not produced and/or provided a reflective piece to the NMC, and in previous responses to the NMC, had sought to blame others, stating that he was not the only one responsible for the issues in the Home, despite him being clinical lead for part of the time where the panel found him responsible.

The panel determined that it has no evidence before it that Mr Adams has worked as a nurse for a sustained period of time where he has practised effectively without any problems and therefore cannot assume that if Mr Adams were to find himself in a similar situation in the future he would act differently. The panel is therefore of the view that there is a risk of repetition.

The panel therefore determined that limbs a-c of the Dame Janet Smith test are also engaged with respect to Mr Adams' future conduct and determined that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required, and in light of Mr Adams' deplorable behaviour, an informed member of the public would be shocked and concerned if Mr Adams was permitted to return to nursing practise unrestricted. The panel was therefore of the view that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Adams' fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Adams' fitness to practise is currently impaired by reason of his misconduct.

Sanction

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

Ms Norman submitted that any sanction imposed should be proportionate, aiming to protect the public and uphold confidence in the profession. She said the charges found proved, which were found to amount to misconduct and impairment, fall into three groups: failures in record-keeping (Charges 3), failures in patient care (Charges 6, 17 and 18b), and attitudinal failings (Charges 25 to 29), including deplorable text messages that bring the nursing profession into disrepute.

Ms Norman submitted that the aggravating factors include Mr Adams' lack of insight, the ongoing nature of the misconduct, and the risk of harm to patients, and actual harm/distress caused, particularly in relation to a distressing manual evacuation incident. She said there are no identifiable mitigating factors, as there has been no engagement in the process or evidence of insight.

Ms Norman referred the panel to the latest NMC Guidance on Sanctions, particularly concerning discriminatory behaviour. She said that this guidance states that where there is no early demonstration of remorse, insight, or strengthened practice, and where the registrant denies the issue or fails to engage, a serious sanction such as removal from the register may be required to maintain public trust.

Ms Norman submitted that lesser sanctions, such as a caution or conditions of practice order, are inappropriate due to the nature and seriousness of the findings. She said a suspension order is also not suitable as Mr Adams does not meet the relevant criteria, including insight and low risk of repetition.

Ms Norman stated that, given the seriousness and breadth of the concerns, the attitudinal nature of the failings, and the harm caused, the NMC submits that the only appropriate sanction in this case is a striking-off order.

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

Decision and reasons on sanction

Having found Mr Adam'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 and gave particular consideration to the guidance on seriousness and

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

The panel took account of the NMC guidance: 'How we determine seriousness' and the three broad categories of factors which may indicate the seriousness of a case as follows:

- *'Serious concerns which are more difficult to put right.*
- *Serious concerns which could result in harm to patients if not put right.*
- *Serious concerns based on the need to promote public confidence in nurses, midwives, and nursing associates.'*

In particular the panel took into account that some behaviours are particularly serious as they suggest there may be a risk to people receiving care; examples include:

- *'conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care,*

- *discrimination…'*

The panel took into account the following aggravating features:

- Putting patients at risk of harm and causing actual harm
- Pattern of behaviour over time and across multiple areas of care
- Very limited insight
- Deeply offensive, racist, and discriminatory text messages

The panel also took into account the following mitigating features:

- Limited experience in managing systems and processes for record keeping as well as in monitoring the care provided by other staff

- A lack of clinical support and supervision concerning the clinical lead role alongside an absent clinically trained homeowner and a non-clinical home manager
- No job description supplied for the clinical lead role and very limited time allocated to carry out this role

Mr Adams stated that he had completed a Continuing professional development (CPD) course in wound care, but no certificate was submitted, and Mr Adams provided no information about how the course had strengthened his practice.

In its approach to sanction, the panel had regard to the principle of proportionality.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of its findings on facts and impairment, and the public protection issues identified, an order that does not restrict Mr Adams' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where:

> *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel considered that Mr Adams' misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of its findings on facts and impairment. 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 Mr Adams' registration would be an appropriate sanction. The panel recognised that some elements of the charges relating to patient care might, in isolation, be manageable through

conditions. However, Mr Adams has had limited engagement with the NMC and there is no evidence that Mr Adams would comply with any conditions that were imposed. Furthermore, the charges concerning racism and discriminatory behaviour are attitudinal in nature, and Mr Adams has demonstrated very limited insight into his misconduct.

The panel took particular note of the following elements of the SG regarding the suitability of conditions of practice:

- no evidence of harmful deep-seated personality or attitudinal problems
- …
- …
- potential and willingness to respond positively to retraining
- …
- patients will not be put in danger either directly or indirectly as a result of the conditions
- the conditions will protect patients during the period they are in force
- conditions can be created that can be monitored and assessed.

The panel considered that the criteria above indicate that conditions of practice would not be appropriate.

The panel concluded that, given the nature and seriousness of the charges found proved, there are no practical or workable conditions that could be formulated. The misconduct involved discriminatory and racist behaviour, which the panel considered could not be adequately addressed through remediation or retraining.

The panel determined that there is evidence of deep-seated attitudinal problems. In light of Mr Adams' limited insight and his limited engagement with the NMC or the fitness to practise proceedings, the panel was satisfied that patients would be placed at risk if he were permitted to practise under conditions.

Accordingly, the panel concluded that the imposition of conditions of practice would not be sufficient to address the seriousness of the misconduct, nor would it be adequate to protect the public or maintain confidence in the profession.

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

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

The panel considered that the criteria above indicate that a suspension order would not be appropriate.

In this particular case, the panel therefore 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?*

Mr Adams' conduct consisted of significant departures from the standards expected of a registered nurse and is fundamentally incompatible with him remaining on the NMC register. The panel was of the view that the findings in this particular case demonstrate that Mr Adams' actions were very serious, for example the manual evacuation and the racist and discriminatory text messages that he sent. It considered that to allow him to continue practising would not protect the public and would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

The panel determined that Mr Adams' conduct raises fundamental questions about his professionalism. The panel considered that the misconduct involved multiple and wide-ranging areas, is serious and breached multiple areas of the Code.

Having regard to his clinical failings, the panel was of the view that Mr Adams presented a material risk to the public should he continue practising at this time and, in addition, because of his failings, the most serious sanction is justified in this case in order to declare and uphold proper standards and maintain public trust and confidence in nurses, midwives and nursing associates.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Adams' actions is fundamentally incompatible with him remaining on the register.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

The panel considered that this order was necessary to protect the public and 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.

This decision will be confirmed to Mr Adams in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Norman. She submitted that an interim suspension order is necessary to cover the period until the striking-off order comes into effect having regard to the panel's findings. Ms Norman submitted that if Mr Adams appeals the decision of the panel, then he would be able to practice without restrictions until the appeal process is finished and this can take up to 18 months. She invited the panel to impose an order for a period of 18 months to cover the whole of the appeal period.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order.

Given the uncertainty in relation to any potential appeal period, the panel imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.