Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 15 January 2024 – Tuesday, 30 January 2024
Tuesday, 26 March 2024 – Thursday, 28 March 2024
Monday, 24 June 2024, Wednesday, 26 June 2024 – Thursday, 27 June 2024
(Panel in-camera)
Monday, 22 July 2024 – Tuesday, 23 July 2024
(Panel in-camera)
Monday, 9 September 2024 – Friday, 13 September 2024
(Panel in-camera)
Monday, 14 October 2024 – Friday 18, October 2024
(Panel in-camera)
Monday, 13 January 2025 – Friday, 17 January 2025
Wednesday 11 June 2025 – Thursday 12 June 2025
Wednesday 30 July 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Rohini Persand**
NMC PIN:	99B0913E
Part(s) of the register:	RNMH, Registered Nurse – Mental Health (22 February 2002)
Relevant Location:	Kent and Surrey
Type of case:	Misconduct
Panel members:	Ashwinder Gill (Chair, Lay member) Sally Underwood (Registrant member) Linda Redford (Lay member)
Legal Assessor:	Suzanne Palmer (15 – 19 January 2024) Megan Ashworth (22 – 26 January 2024) Patricia Crossin (29 – 30 January 2024) Michael Levy (26 – 28 March 2024, 26 – 27 June 2024) Jayne Wheat (24 June 2024, 22 – 23 July 2024, 9 – 13 September 2024, 14 – 18 October 2024, 13 – 17 January 2025, 11 – 12 June 2025 and 30 July 2025)

Hearings Coordinator:	Yewande Oluwalana (15 January 2024 – 27 June 2024, 23 July 2024, 14 -18 October 2024, 13 -17 January 2025) Dilay Bekteshi (22 July 2024) Shela Begum (9 -13 September 2024, 11 – 12 June 2025 and 30 July 2025)
Nursing and Midwifery Council:	Represented by Holly Girven, Case Presenter
Mrs Persand:	Present and unrepresented (15 – 16 January 2024, 19 – 30 January 2024, 26 – 28 March 2024) Not present and unrepresented (18 January 2024) Present and unrepresented (15 – 17 January 2025) Not present and unrepresented (11 – 12 June 2025) Present and unrepresented (30 July 2025)
Facts proved by admission:	Charge 18
Facts proved:	Charge 1a. Schedule A (8), Charge 4a. Schedule D (3), Charge 6a. Schedule F (6), Charge 7a. Schedule G (7,8 and 9) Charge 15a Schedule O (1), Charge 17a. Schedule Q (1, 2a, 2b, 2c, 3a, 3b, 3c, 4a, 4b, 6, 9 and 10), Charge 17b. Schedule R (1, 2a, 2b, 2c, 3a, 3b, 6, 7a, 7b, 9 and 10), Charges 19a, 19b, 19c, 20b and 20c
Facts not proved:	Charges 1a. Schedule A (1,2,3,4,5,6,7,9,10,11 and 12), 1b, Charges 2a. Schedule B (1,2,3 and 4), 2b, Charges 3a. Schedule C (1,2,3), 3b, Charges 4a. Schedule D (1 and 2), 4b, Charges 5a. Schedule E (1, 2 and 3), 5b., Charges 6a. Schedule F (1,2,3,4,5 and 7), 6b., Charges 7a. Schedule G (1,2,3,4,5,6,10,11,12,13,14,15,16,17,18,19a, 19b, 20a and 20b,), 7b, Charges 8a. Schedule H(1,2,3,4 and 5), 8b, Charges 9a. Schedule I (1a, 1b and 2), 9b, Charges 10a. Schedule J (1,2,3,4 and 5), 10b., Charges 11a. Schedule K (1,2,3,4 and 5), 11b, Charges 12a. Schedule L (1,2,3,4,5, 6 and 7) , 12b., Charges 13a. Schedule M (1,2,3,4,5,6,7,8,and 9), 13b., Charges 14a. Schedule N (1,2, and 3), 14b., Charges 15a. Schedule O (2, 3,4, 5, 6, 7 and 8), 15b. Charges 16a. Schedule P (1 and 2), 16b., Charges 17a. Schedule Q (5, 7 and 8),

	Charges 17b. Schedule R (4, 5 and 8), 17c, Charge 20a
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim Order:	**Interim suspension order (18 months)**

Details of charge (as amended)

‘That you, a registered nurse, whilst working as a registered nurse and/or Registered Manager at the Abbey Court Care Home (‘the Home’) between 01 October 2010 and 11 May 2020:

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

    a) As set out in Schedule A;
    b) Generally; [**FOUND NOT PROVED]**

2) Failed to ensure that the services delivered/provided at the Home were effective/delivered in an effective manner:

    a) As set out in Schedule B;
    b) Generally; [**FOUND NOT PROVED]**

3) Failed to ensure that services delivered/provided at the Home were provided/delivered in a caring manner:

    a) As set out in Schedule C;
    b) Generally; [**FOUND NOT PROVED]**

4) Failed to ensure that services delivered/provided at the Home were responsive to the service users needs:

    a) As set out in Schedule D;
    b) Generally; [**FOUND NOT PROVED]**

5) Failed to ensure that services delivered/provided at the Home were well-led/supervised:

a) As set out in Schedule E;
b) Generally; [**FOUND NOT PROVED]**

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule F;
b) Generally; [**FOUND NOT PROVED]**

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule G;
b) Generally; [**FOUND NOT PROVED]**

8) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule H;
b) Generally; [**FOUND NOT PROVED]**

9) Failed to ensure that the Home employed safe and proper persons and/or complied with regulations 19(1), 19(2) and 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule I;
b) Generally; [**FOUND NOT PROVED]**

10) Failed to ensure that the Home was meeting the nutrition and hydration needs of service users and/or complied with regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule J;
b) Generally; [**FOUND NOT PROVED]**

11) Failed to ensure that the Home was adequately complying with the consent to care requirements of service users and/or complied with regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule K
b) Generally; [**FOUND NOT PROVED]**

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule L;
b) Generally; [**FOUND NOT PROVED]**

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule M;
b) Generally; [**FOUND NOT PROVED]**

14) Failed to ensure that the Home effectively received/handled complaints and/or complied with regulations 16(1) and 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule N;
b) Generally; [**FOUND NOT PROVED]**

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the

regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule O;
b) Generally; [**FOUND NOT PROVED]**

16) Failed to ensure that you/the Home notified the CQC of notifiable incidents and/or complied with regulations 18 of the Care Quality Commission (Registration) Regulations 2009

a) As set out in Schedule P;
b) Generally; [**FOUND NOT PROVED]**

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;
b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;
c) Generally; **[FOUND NOT PROVED]**

That you, a registered Band 5 Nurse, whilst working at Margaret Laurie House Rehabilitation Unit:

18) On 6 October 2019, left the Home without qualified nursing cover/staffing during a shift; **[FOUND PROVED BY ADMISSION]**

19) Having left the Home without qualified nursing cover/staffing on 6 October 2019 as referred to in charge 18 above, you:

a) On, or around, 6 October 2019, inappropriately asked HCA 1 if you could record on SystmOne that HCA 1 had returned Patient A; **[FOUND PROVED]**

b) On, or around, 6 October 2019, inaccurately recorded/wrote that staff had returned Patient A; **[FOUND PROVED]**

c) On, or around, 7 October 2019, said in the presence of Manager 1 words to the effect that HCA 1 had gone to fetch Patient A; **[FOUND PROVED]**

20) Your conduct at any and/or all of charges 19(a)- (c) inclusive above was dishonest in that you:

a) Knew that you had left the Home to return Patient A; **[FOUND NOT PROVED]**

b) Intended to conceal that you had left the Home; **[FOUND PROVED]**

c) Intended to create the misleading impression as to the events involving Patient A on 6 October 2019 **[FOUND PROVED]**

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

SCHEDULE A

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	A	Did not have in place robust arrangements to manage and support the resident's condition of diabetes **[FOUND NOT PROVED]**

2		No record of equipment checks/checks that equipment was set to the correct pressure for one, or more, service users **[FOUND NOT PROVED]**
3	B	The records examined for the resident showed that the service user was only assisted repositioned 3 times per day, whereas their skin integrity plan stated that the service user should be repositioned every 2- 3 hours **[FOUND NOT PROVED]**
4	C	No guidance provided in relation to the administration of paracetamol for pain relief **[FOUND NOT PROVED]**
5	A	No guidance provided in relation to the administration of Senna for constipation **[FOUND NOT PROVED]**
6	D	No guidance provided in relation to the administration of Zapain for pain relief **[FOUND NOT PROVED]**
7	A	Did not have in place a process for safe medication stock management and/or ensure that such a process was followed **[FOUND NOT PROVED]**
8		Did not ensure that service users were fully/adequately protected from the risk of fire **[FOUND PROVED]**
9		Did not ensure that the Home was being cleaned to suitable standard to promote good hygiene/prevent and control the risk of infection **[FOUND NOT PROVED]**
10		Did not have a formal/appropriate system was used to ensure that sufficient levels of staff were on duty **[FOUND NOT PROVED]**
11		Did not ensure that adequate background checks were undertaken for one, or more, members of staff **[FOUND NOT PROVED]**

12		Did not ensure that a hole in floor of the corridor covered by a mat was repaired timeously **[FOUND NOT PROVED]**

SCHEDULE B

2) Failed to ensure that the services delivered/provided at the Home were effective/delivered in an effective manner

	Service User	**Event**
1		Did not ensure that one, or more, members of staff were fully supported/received training and guidance to support service users who were living with dementia **[FOUND NOT PROVED]**
2	D	Did not ensure that suitable support arrangements/training was in place to support this service user who had dementia **[FOUND NOT PROVED]**
3	E	Did not ensure that suitable support arrangements/training was in place to support this service user who had dementia **[FOUND NOT PROVED]**
4		Did not ensure that the Home accommodation was designed/adapted/decorated to meet the needs of service users and/or comply with regulation 15(1)(c) and (e) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2004 **[FOUND NOT PROVED]**

SCHEDULE C

3) Failed to ensure that services delivered/provided at the Home were provided/delivered in a caring manner:

	Service User	Event
1		Did not ensure that staff used English as their first language/provided effective communication with service users **[FOUND NOT PROVED]**
2	Unknown	Did not ensure that the service user received appropriate/ supportive care in their request to access the garden **[FOUND NOT PROVED]**
3		Did not ensure that one, or more, service user had access to keys to their bedroom doors **[FOUND NOT PROVED]**

SCHEDULE D

4) Failed to ensure that services delivered/provided at the Home were responsive to the service users' needs

	Service User	Event
1	A, J, & H	Did not ensure that one, or more, service user(s)were consulted when their care plans were reviewed/updated **[FOUND NOT PROVED]**
2		Did not ensure that care plans / records were presented in an accessible manner **[FOUND NOT PROVED]**
3		Did not ensure that social activities were appropriately managed and/or delivered and/or recorded **[FOUND PROVED]**

SCHEDULE E

5) Failed to ensure that services delivered/provided at the Home were well-led/supervised:

	Service User	**Event**
1		Did not ensure that robust quality checks were undertaken/shortfalls in service quickly remediated **[FOUND NOT PROVED]**
2		Did not ensure that that the Accessible Information Standard 2016 was appropriately met **[FOUND NOT PROVED]**
3		Did not ensure that the Home accommodation met the standards of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2004 **[FOUND NOT PROVED]**

SCHEDULE F

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	N	Did not adequately investigate allegations brought to you attention by Kent County Council that on, or around 22 October 2019, that Staff Member 2 has been speaking to Service User N in an offensive/threatening/sexual manner **[FOUND NOT PROVED]**
2	N	Did not limit or supervise contact between Staff Member 2 and Service User N, following allegations of abuse being brought to you attention by Kent County Council on, or around 22 October 2019 and/or 5 November 2019 **[FOUND NOT PROVED]**

3	K	Did not adequately investigate allegations of abuse made by Service User K against Staff Member 2 **[FOUND NOT PROVED]**
4	K	Did not report allegations of abuse raised by Service User K against Staff Member 2 to (a) the CQC and/or Kent County Council **[FOUND NOT PROVED]**
5		Did not promptly notify the Disclosure and Barring Service of Staff Member 2's dismissal **[FOUND NOT PROVED]**
6		Did not take appropriate precautions to safeguard service users from the risk of abuse by Staff Member 1 **[FOUND PROVED]**
7		Did not ensure that any and/or all of Staff Members 1, 2, 3 and 4 had received training in how to adequately respond to abuse **[FOUND NOT PROVED]**

SCHEDULE G

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

	Service User	**Event**
1		Did not ensure that any and/or all of Staff Members 1, 2, 3 and 4 knew the correct fire procedures and/or how to follow the Personal Emergency Evacuation Plan ('PEEP') for one, or more, service users **[FOUND NOT PROVED]**
2	D	Did not ensure that the information in the service users PEEP was complete/accurate **[FOUND NOT PROVED]**

3	J	Did not ensure that the information in the service users PEEP was complete/accurate **[FOUND NOT PROVED]**
4	K	Did not ensure that the information in the service users PEEP was complete/accurate **[FOUND NOT PROVED]**
5		Did not ensure that one, or more, members of staff attended a fire drill at least every 3 months **[FOUND NOT PROVED]**
6		Did not endure that ongoing checks of the Home's emergency lights were undertaken as appropriate **[FOUND NOT PROVED]**
7	L	Did not ensure that Service User L and/or other services users with reduced mobility were assisted to transfer safely and/or with the assistance of at least 2 members of staff **[FOUND PROVED]**
8	L	Did not ensure that an appropriate/full-body sling was used for Service User L when transferring to the toilet **[FOUND PROVED]**
9	D	Did not ensure that an appropriate/'in situ' sling was used for Service User D **[FOUND PROVED]**
10	K	Did not ensure that staff encouraged Service User K to change position in bed and/or that consistent arrangements were undertaken by staff to do so **[FOUND NOT PROVED]**
11	J	Did not ensure that staff encouraged Service User J to change position in bed and/or that consistent arrangements were undertaken by staff to do so **[FOUND NOT PROVED]**
12	K	Did not ensure that appropriate instructions/processes were in place to provide appropriate/safe catheter care for Service User K

		[FOUND NOT PROVED]
13	K	Did not ensure that Service User K was consistently supported to eat and drink safely **[FOUND NOT PROVED]**
14	J	Did not ensure that Service User J was consistently assisted to sit in an upright position when eating and drinking to reduce the risk of choking **[FOUND NOT PROVED]**
15		Did not ensure that staff were provided with written/appropriate guidance about providing emergency first aid if a service user choked **[FOUND NOT PROVED]**
16	L	Did not ensure that one, or more, staff were aware/followed Service User L's care plan in relation to their cheese allergy **[FOUND NOT PROVED]**
17		Did not ensure that medicines were managed safely **[FOUND NOT PROVED]**
18	M	Did not ensure that the administration of Hydroxocobalamin to Service User M between 26 November 2019 and 22 December 2019 was countersigned **[FOUND NOT PROVED]**
19	M	Did not ensure that Service User M received the correct dose of Oxypro (5mg) and/or the correct dose was accurately recorded on: a) 9 December 2019; b) 14 December 2019 **[FOUND NOT PROVED]**
20	J	Did not ensure accident forms/reports were accurately completed in respect of Service User J in relation to incidents on: a) 16 November 2019;

		b) 19 November 2019 **[FOUND NOT PROVED]**

SCHEDULE H 8) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014		
	Service User	**Event**
1		Did not consistently ensure that a sufficient number of staff members were working on shifts to meet the needs of service users **[FOUND NOT PROVED]**
2	N & A	Did not ensure that staff were available on 19 December 2019 to timeously assist: a) Service User N; b) Service User A **[FOUND NOT PROVED]**
3		Did not ensure that one, or more, staff members were adequately supervised and/or such supervision was adequately recorded; **[FOUND NOT PROVED]**
4		Did not ensure that one, or more, staff members, including Staff Members 1, 2 3 and 4 had all the knowledge and skills need to consistently provide safe care/care in line with national guidance **[FOUND NOT PROVED]**
5	D	Did not ensure that staff were given guidance in care plans and have the competencies needed to consistently support Service User D's needs arising from dementia

		[FOUND NOT PROVED]

SCHEDULE I

9) Failed to ensure that the Home employed safe and proper persons and/or complied with regulations 19(1), 19(2) and 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

	Service User	**Event**
1		Did not ensure that a full and continuous employment history was obtained as part of the pre-employment checks for: a) Staff Member 2; b) Staff Member 3 **[FOUND NOT PROVED]**
2		Did not fully investigate the suitability of Staff Member 6, who had received two police cautions for violent conduct, to be employed at the Home **FOUND NOT PROVED**

SCHEDULE J

10) Failed to ensure that the Home was meeting the nutrition and hydration needs of service users and/or complied with regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	J	Did not ensure that accurate records were kept for meals taken by Service User J on one, or more, occasion between 16 December 2019 and 22 December 2019 **[FOUND NOT PROVED]**

2	K	Did not ensure that accurate records were kept for meals taken by Service User K on one, or more, occasion between 16 December 2019 and 22 December 2019 **[FOUND NOT PROVED]**
3	L	Did not ensure that accurate records were kept for meals taken by Service User L on one, or more, occasion between 16 December 2019 and 22 December 2019 **[FOUND NOT PROVED]**
4	F	Did not ensure that that one, or more, staff members knew about/recorded the target amount of fluid for Service User F **[FOUND NOT PROVED]**
5	O	Did not ensure that that one, or more, staff members knew about/recorded the target amount of fluid for Service User O **[FOUND NOT PROVED]**

SCHEDULE K

11) Failed to ensure that the Home was adequately complying with the consent to care requirements of service users and/or complied with regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	N	Did not ensure that suitable provision had been made to obtain consent in line with the Mental Capacity Act 2005 **[FOUND NOT PROVED]**
2	D	Did not ensure that an assessment was completed to see if Service User D had the mental capacity to consent to sharing a bedroom **[FOUND NOT PROVED]**

3	O	Did not ensure that relatives and/or healthcare professionals were consulted in relation to Resident O who was regularly encouraged to have bed rest in the afternoon **[FOUND NOT PROVED]**
4	L	Did not ensure a condition relating to a review as to whether Service User L should be resuscitated was completed/recorded **[FOUND NOT PROVED]**
5		Did not know whether conditions were imposed on one, or more, authorisations under the Mental Capacity Act 2005 and/or ensure that Staff Members 1, 2, 3, 4 and/or 5 were aware of such conditions **[FOUND NOT PROVED]**

SCHEDULE L

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	O	Did not ensure that Staff Member 3 communicated/engaged with Service User O appropriately when assisting them with eating on 19 December 2019 **[FOUND NOT PROVED]**
2	A	Did not ensure that Staff Member 4 promoted the privacy/ dignity of Service User A when using the toilet on 19 December 2019 **[FOUND NOT PROVED]**
3	L	Did not ensure that Staff Member 4 promoted the privacy/ dignity of Service User L when using the toilet on 19 December 2019 **[FOUND NOT PROVED]**

4	O	Did not ensure that Staff Member 4 supported Service User O in actively making a decision as to whether to go to their bedroom or remain in the lounge on 19 December 2019 **[FOUND NOT PROVED]**
5		Did not ensure that and and/or all of Staff Members 1, 3, 4 and 5 were able to communicate effectively with service users **[FOUND NOT PROVED]**
6		Did not ensure that one, or more, service user with mental capacity were provided with a key to lock their bedroom **[FOUND NOT PROVED]**
7		You did not develop links with local lay advocacy resources and/or understand the need to do so **[FOUND NOT PROVED]**

SCHEDULE M

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	K	Did not ensure that Service User K was involved./consulted in relation to their care plans in, or around, 3 months prior to the inspection on 19 December 2019 **[FOUND NOT PROVED]**
2	F	Did not ensure that Service User F was involved./consulted in relation to their care plans in, or around, 3 months prior to the inspection on 19 December 2019 **[FOUND NOT PROVED]**
3	D	Did not ensure that the reviews of Service User D's care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019

		[FOUND NOT PROVED]
4	M	Did not ensure that the reviews of Service User M's care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019 **[FOUND NOT PROVED]**
5	O	Did not ensure that the reviews of Service User O's care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019 **[FOUND NOT PROVED]**
6		Did not ensure that information was presented to one, or more, service user in an accessible manner and/or as required by the Accessible Information Standard 2016 **[FOUND NOT PROVED]**
7	N	Did not ensure that Service User N was appropriately assisted by Staff Member 3 in relation to their food choice in, or around December 2019 **[FOUND NOT PROVED]**
8	L	Did not ensure that Service User L was appropriately supported to access support/activities during the period 19 November 2019 and 3 December 2019 **[FOUND NOT PROVED]**
9	O	Did not ensure that Service User O was appropriately supported to access support/activities during the period 19 November 2019 and 3 December 2019 **[FOUND NOT PROVED]**

SCHEDULE N

14) Failed to ensure that the Home effectively received/handled complaints and/or complied with regulations 16(1) and 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1		Did not ensure that your complaints policy and procedures were accessible to one, or more, service users **[FOUND NOT PROVED]**
2	K	Did not ensure that Service User K's complaint relating to food between September 2019 and November 219 was appropriately investigated and/or resolved **[FOUND NOT PROVED]**
3	O	Did not ensure that a complaint on behalf of Service User O relating to wheelchair positioning between September 2019 and November 2019 was appropriately investigated and/or resolved **[FOUND NOT PROVED]**

SCHEDULE O

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1		Did not ensure that robust systems and processes to assess monitor and improve the quality and safety of the service were established as at 19 December 2019 **[FOUND PROVED]**

2		Did not ensure that adequate audit relating to medicines management were undertaken as at the date of the inspection on 19 December 2019 **[FOUND NOT PROVED]**
3		Did not ensure that service users were consulted regarding the development of the service **[FOUND NOT PROVED]**
4		Did not ensure that any and/or all of Staff Members 1, 2, 3, 4 and 5 were suitably supported/trained to understand their responsibilities and provide safe and effective care **[FOUND NOT PROVED]**
5		Did not ensure that effective 'handover' of care was provided/implemented **[FOUND NOT PROVED]**
6	K	Did not ensure that the care plan audit completed on 20 May 2019 identified/addressed shortfalls relating to arrangements for Service User K to drink safely **[FOUND NOT PROVED]**
7	L	Did not ensure that the care plan audit completed on 20 May 2019 identified/addressed the unsafe practice relating Service User L being transferred by hoist **[FOUND NOT PROVED]**
8	D	Did not ensure that the care plan audit completed on 27 December 2019 identified/addressed the need for Service User D to be transferred using an 'in-situ' sling **[FOUND NOT PROVED]**

SCHEDULE P

16) Failed to ensure that you/the Home notified the CQC of notifiable incidents and/or complied with regulations 18(5) (b) (11) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	Event
1	N	Did not notify the CQC of allegations brought to you attention by Kent County Council that on, or around 22 October 2019, that Staff Member 2 has been speaking to Service User N in an offensive/threatening/sexual manner **[FOUND NOT PROVED]**
2		Did not notify the CQC of Staff Member 2's dismissal **[FOUND NOT PROVED]**

SCHEDULE Q

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council, as at the date of the inspection of 30 May 2019

	Service User	Event
1		Did not ensure that the Home was free from trip hazards, in that there was a hole in the floor and/or the carpet needed replacing **[FOUND PROVED]**
2	M	Did not ensure that Resident M's care plan provided appropriate information in relation to: a) SALT/diet and risk of choking; b) Hearing; c) Skin integrity **[FOUND PROVED]**
3	J	Did not ensure that in relation to Resident J: a) their falls record consistently matched the accident recordings log within the Home; b) a self- harming risk assessment was in place;

		c) their eating and drinking SALT Guidelines were included in their care plans **[FOUND PROVED]**
4	O	Did not ensure that in relation to Resident O: a) their care plan reflected the occupational therapy recommendation; b) their care plan reflected how their skin integrity should be managed **[FOUND PROVED]**
5		Did not ensure that one, or more, resident's daily notes were reflective of the choices offered to them and/or showed how each resident's day looked on any given day **[FOUND NOT PROVED]**
6	J	Did not ensure that appropriate actions/responses were undertaken and/or recorded in relation to Resident J, who had slipped off of their chair 4 times between September and December 2018 **[FOUND PROVED]**
7		Did not ensure that one, or more accident/incidents were accurately/appropriately recorded **[FOUND NOT PROVED]**
8		Did not ensure that the Deprivation of Liberty ('DoLS') tracker was kept up to date **[FOUND NOT PROVED]**
9		Did not ensure that one, or more, residents had their own room and/or the reasons for any residents who shared a room were recorded **[FOUND PROVED]**
10		Did not ensure that one, or more, smoke detectors were replaced/working between 15 February 2019 and 30 May 2019 **[FOUND PROVED]**

SCHEDULE R

Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council, as at the date of the inspection on 22 October 2019

	Service User	**Event**
1		Did not ensure that one, or more, items of the Action Plan following the inspection of Kent County Council on 30 May 2019 were completed **[FOUND PROVED]**
2		Did not ensure that one, or more, of the following environmental safety concerns were addressed: a) rubbish piled in the garden and/or bins at the front of the Home overflowing; b) Safe use of extension leads/electrical systems; c) Split wheelchair cushions posing an infection risk; **[FOUND PROVED]**
3		Did not ensure that one, or more, of the following health and safety concerns were addressed: a) Fire door being propped open with objects and furniture; b) The condition of the shower room; **[FOUND PROVED]**
4	D	Did not ensure that the resident's care file(s) were complete and/or accurate and/or consistent **[FOUND NOT PROVED]**
5	K	Did not ensure that the resident's care file(s) were complete and/or accurate and/or consistent **[FOUND NOT PROVED]**
6	K	Did not ensure that one, or more, of the daily care notes contained appropriate detail and/or was legible, including: a) Resident K **[FOUND PROVED]**

7	D	Did not ensure that appropriate care was provided to one, or more residents including: a) Resident D in relation to supervision whilst eating; b) 5 additional residents who were observed unsupervised during lunch **[FOUND PROVED]**
8		Did not ensure that a new carer spoke to a resident who was unsettled in an appropriate way on 22 October 2019 **[FOUND NOT PROVED]**
9		Did not ensure that appropriate/suitable activities were available for the residents at the Home **[FOUND PROVED]**
10		Did not ensure that appropriate steps to meet the dietary needs of one, or more, residents **[FOUND PROVED]**

Background

The charges arose from two settings, charges 1 – 17 relate to your role as a Registered Manager at Abbey Court Care Home ('the Home') and charges 18 – 20 relate to your employment at [PRIVATE] Rehabilitation Unit ('the Unit'), Surrey and Borders Partnership NHS Foundation Trust ('the Trust').

You were the CQC Registered Manager of the Home from 1 October 2010 until the Home ceased to be registered in April 2020. The Home is a 'nursing care home' providing nursing care for up to 22 older people. The Home was operated by Abbey Health Care Ltd. Registered Persons are required to ensure the relevant regulations are met. Since 2014 this has been a requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Prior to 2014 this was under the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Kent County Council (KCC) had a service contract with the Home.

From November 2011 to December 2019, whilst you were the Registered Manager of the Home, alleged failures were identified by CQC during a series of inspections over a number of years. Many of the alleged concerns related to fundamental areas of care. Despite improvements in some areas, alleged concerns continued to be raised particularly in respect of record keeping and the completion of monitoring checks on the systems in place.

On 6 February 2020 the CQC issued a Notice of Proposal to cancel the registration of the Home. On 12 February 2020, the KCC cancelled its contract with you and removed all its residents. Following a decision on 10 March 2020, with effect from 21 April 2020, the Home's registration was cancelled by the CQC. Your registration as a Registered Manager was cancelled on 11 May 2020.

A further referral was received from the manager of the Unit. You were employed part time as a Band 5 Staff Nurse. It is alleged that on 6 October 2019 you left the Unit to find a patient who had left the Unit earlier and, in doing so, the Unit was left without qualified nursing cover. Following this it is alleged you provided a false account of the event by asking another member of staff if you could record that the other member of staff had returned the patient to the Unit and not you. It is alleged that you had dishonestly told your manager that another member of staff had returned the patient to the Unit following the incident.

Decision and reasons on applications for parts of the hearing to be held in private

At the outset of the hearing, Ms Girven on behalf of the Nursing and Midwifery Council (NMC) made an application that parts of this hearing be held in private as there will be reference [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You indicated that you supported the application.

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

Having heard that there will be some reference [PRIVATE], the panel determined to hold those parts of the hearing in private in order to protect your privacy. It considered that your right to privacy in relation to sensitive information outweighed the public interest in the proceedings being held entirely in public.

At the outset of Witness 2's evidence on the second day of the hearing, Ms Girven made a further application under Rule 19 for parts of the hearing to be held in private as reference would be made to Witness 2's [PRIVATE].

You indicated that you did not oppose the application.

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

Having heard that there will be some reference to Witness 2's [PRIVATE], the panel determined to hold those parts of the hearing in private in order to protect Witness 2's privacy. It considered that Witness 2's right to privacy in relation to [PRIVATE] outweighed the public interest in the proceedings being held entirely in public.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Girven under Rule 31 to allow the following exhibits by Witnesses 2, 3 and 4 to be admitted into evidence:

- Witness 2's exhibits – 2, 8, 9, 11 (Appendix 9) and 12

- Witness 3's exhibits – 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 13
- Witness 4's exhibits – 4 to 6

Ms Girven submitted that Witness 2 and 3 exhibited Care Quality Commission (CQC) inspection reports spanning December 2011 to 2019. Within Witness 2's exhibits, a report was provided by Ms 1 who had attended a CQC inspection in December 2018 with Witness 2 but had not been called by the NMC to give evidence in the hearing. Also, within Witness 2's evidence he provided a bundle of appendices for the notice of proposal specifically Appendix 9 which was an Occupational Therapist report on behalf of Kent County Council, and a document titled Notice of Decision dated 10 March 2020. Ms Girven said that Witness 4 exhibited emails as part of her evidence.

Ms Girven referred the panel to the case of *Thorneycroft v NMC* [2014] EWHC 1565 (Admin) and what it should consider when deciding on whether to allow hearsay evidence. She highlighted the test that panel needed to consider:

(1) whether the statements were the sole or decisive evidence in support of the relevant allegations,
(2) the nature and extent of the challenge to the contents of the statements,
(3) whether there was any suggestion that the witnesses had reasons to fabricate their allegations,
(4) the seriousness of the charge, taking into account the impact which adverse findings might have on your career,
(5) whether there was a good reason for the non-attendance of the witnesses,
(6) whether the NMC had taken reasonable steps to secure their attendance, and
(7) whether or not you had prior notice that the witness statements were to be read.

Ms Girven submitted that Witnesses 2, 3 and 4 will be giving live evidence in the hearing and that the exhibits do not form the sole and decisive evidence upon which the NMC seeks to rely. She further submitted that the CQC inspection reports are historical, and it was not clear who the authors of the reports were. The NMC did not attempt to contact the CQC to ascertain this information as it was felt not to be

proportionate. Ms Girven submitted that there was no evidence to suggest that the authors of the reports would fabricate these documents as these are public records and as such it would be fair and appropriate to admit the evidence, especially the CQC reports. Ms Girven acknowledged that you did not have prior notice of this application.

Ms Girven submitted that Witness 2 will provide evidence in relation to the inspection carried out in December 2018 in which Ms 1 produced a report. She submitted that you would have the opportunity to question the witnesses about the exhibits, even though they were not the authors of the documents. Ms Girven submitted that the evidence was relevant and that it would be fair in the circumstances to admit it.

You told the panel that you oppose the application made by the NMC, as you do not agree with the information within the CQC inspection reports.

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 that Rule 31 provides that, subject to the requirements of relevance and fairness, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application in regard to the exhibits contained within Witnesses 2, 3 and 4's evidence serious consideration. The panel noted that live evidence will be heard from Witnesses 2, 3 and 4 in relation to the specific charges and that there will be an opportunity during the hearing for you to cross- examine the witnesses who produced the documents in question.

The panel noted that your objection was based on your view that the reports inaccurately describe what was happening at the Home at the time of the various inspections. This was something that you could explore by questioning the witnesses who exhibited the reports. The panel was of the view that it would not have been practical to require the authors of the historic CQC investigation reports to give evidence. It also considered that it was reasonable for the NMC not to have done so. It noted that the purpose of the reports is to provide historic context, showing an

alleged pattern of failures over a period of time. The matters set out in the schedules to the charges are based on the more recent reports, whose authors are available. The panel noted that the reports were written by trained and qualified CQC inspectors and officers of KCC whose role is to give a professional opinion, following an established format. These were public records and there appeared to be no reason to think that these were fabricated.

In these circumstances, the panel determined that the documents were relevant and that it would be fair to accept them into evidence. The panel was mindful that this would be hearsay evidence, and that it would need to consider what weight it was appropriate to give to this evidence when it reached the stage at which it would evaluate all the evidence heard during the proceedings.

Decision and reasons on an application to adjourn the hearing (handed down 18 January 2024)

Before the panel could hear the continuation of Witness 1's evidence on Day 4 of the substantive hearing, it was notified that you were not in attendance at today's hearing. You had called in the afternoon and emailed the Hearings Coordinator on 17 January 2024 at 19:14 requesting an adjournment until next week.

The panel considered whether it should allow your application to adjourn the hearing. It had regard to Rule 32 and heard submissions from Ms Girven.

Ms Girven referred the panel to the email dated 17 January 2024 from you to the Hearings Coordinator requesting an adjournment of today's proceedings. In the email you stated the following,

'[PRIVATE]'

Ms Girven submitted that it was the NMC's primary position that the hearing should proceed in your absence. She said witnesses are on standby to give evidence. However, she acknowledged that given your circumstances the panel is likely to adjourn today.

Ms Girven submitted that although you have requested a postponement until next week, if the panel were minded to grant an adjournment, it should only be until tomorrow morning. This would provide an opportunity to have an update on your [PRIVATE] and to establish whether you would [PRIVATE] and willing to attend the hearing either physically or virtually tomorrow.

Ms Girven said that the panel was due to hear from Witness 1 and Witness 3 today. She said that witness availability has been canvassed and that Witness 1, and Witness 3 would both be available to give evidence via video link within the remaining time scheduled for this hearing. However, Witness 4, who is scheduled to give evidence tomorrow (Friday 19 January 2024), would not be available to give evidence on an alternative day during the scheduled hearing.

Ms Girven invited the panel to proceed in your absence, but, if it was inclined to adjourn the hearing, it should only be until tomorrow morning.

The panel accepted the advice of the legal assessor, which included reference to the case of *Brabazon – Drenning v UKCC* [2001] HRLR 6.

The panel noted that it has a discretionary power to adjourn proceedings under the provisions of Rule 32. It is required by Rule 32 to have regard to the public interest in the expeditious disposal of the case, potential inconvenience to any party or witness, and fairness to you. The panel bore in mind that any decision to proceed in the absence of a registrant should be exercised *'with the utmost care and caution'*.

The panel has decided to grant an adjournment until Friday 19 January 2024 at 09:30 am. In reaching this decision, the panel has considered the submissions of Ms Girven, your email dated 17 January 2024, and the advice of the legal assessor. It has had regard to the overall interests of justice and fairness to all parties. The panel considered:

- [PRIVATE]

- You have made it clear that you wish to continue to engage with the process and attend the hearing.
- You have been present physically from the outset of the hearing and there is nothing to suggest that you would not attend in the future once you are better.
- One witness attended today to give evidence in person, another is due to attend by video link. Witness 4 is due to attend tomorrow and is only available to attend tomorrow.
- Not proceeding may delay the hearing. It may also inconvenience the witnesses and their employer(s). However, the panel was satisfied that the impact of this could be mitigated as, following canvassing of witness availability, Witness 1 and Witness 3 are available to give evidence next week.
- The panel considered in all the circumstances that the interest of fairness to you weighed in favour of granting an adjournment. However, to minimise any delay to the proceedings and in light of Witness 4's unavailability next week, the panel considered that in the first instance the adjournment should only be until tomorrow morning, at which time the situation can be reviewed. [PRIVATE] to continue with the hearing tomorrow, even if your attendance tomorrow is virtual rather than physical.
- The panel considered that you should be asked to provide an update [PRIVATE] by 5pm today, indicating whether [PRIVATE] to continue the hearing tomorrow either by attending physically or, if you can do so, virtually.

In these circumstances, the panel has determined to adjourn the hearing for today and resume tomorrow morning at 09:30 am to review, in light of any update from you, whether and how the hearing can proceed.

The hearing resumed on Friday 19 January 2024

Decision and reasons on an application to admit written evidence from Witness 3

During the course of Witness 3 giving her evidence on Day 6 of the hearing, the panel became aware that Witness 3 had reviewed notes that were not originally exhibited as her evidence. The panel therefore paused Witness 3's evidence in order for all the documents that she had reviewed to be sent to Ms Girven.

On Day 7 of the hearing, the panel heard an application made by Ms Girven under Rule 31 to allow the written notes by Witness 3 to be admitted into evidence.

Ms Girven submitted that the notes should be admitted into evidence as it goes towards the charges and Schedule F 1-5, Schedule G 7-9 and Schedule O 7-8. Ms Girven acknowledged that it was less than ideal for the document to be provided so late during the hearing but submitted that the evidence is fair and relevant. She said that any unfairness to you would be mitigated as Witness 3 is to return and continue with her evidence. This would give you and the panel the opportunity to question the witness on the document and who produced it. Ms Girven said that Witness 3 during her evidence said she was the author of the notes.

Ms Girven submitted that the panel should also consider fairness to the NMC by admitting the evidence as it is relevant to the case and should not be excluded because of the lateness that the evidence was submitted. Ms Girven referred the panel to the case of *Jozi* [2015] EWHC 764 (Admin) and NMC guidance at DMA-6.

You said you objected to the evidence being admitted and felt that it was unfair for the NMC to ask so late to introduce this document when proceedings have started. You said that the NMC has had this case for a long time and should have requested this evidence then. You said it was unfair and that you would not have reasonable time to prepare and challenge the existence of this document.

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

The panel took into account the submissions from Ms Girven and your objections to the application. The panel determined to admit the two-page document into evidence as it was relevant and went specifically to the charges and the schedules (Schedule F 1-5, Schedule G 7-9 and Schedule O 7-8). The panel acknowledged that the notes were provided late in the proceedings, and it considered the manner in which they came to light. Witness 3 volunteered the information part way through her evidence and indicated that she had made reference to the notes while giving evidence. The panel then asked Witness 3 to provide the documents that she looked at during the course of her giving her evidence and this was provided.

The panel next considered the issue of fairness and noted your objections. It was of the view that any unfairness to you can be addressed by you preparing questions to ask the witness when she returns to give evidence. The panel noted that there is a non-sitting day before the witness gives evidence and this should be sufficient time for you to prepare beforehand. The panel also considered the uncertainty of the authorship of the notes, but it determined that this could be addressed when the witness returns to give evidence and can be questioned.

Taking everything into consideration, the panel determined to admit the document into evidence. In the overall interests of fairness to the NMC and to you, it would be fair to admit the evidence. The panel will need to consider what weight was appropriate to give to this document when it reached the stage at which it would evaluate all the evidence heard during the proceedings.

Decision and reasons on facts

On Day 7 of the hearing, before the panel heard from Witness 5, you informed the panel that you would like to admit to charge 18 in its entirety.

The panel therefore finds charge 18 proved in its entirety, by way of your admission.

Decision and reasons on application to amend charges and schedules

The panel heard an application made by Ms Girven, on behalf of the NMC, under Rule 28 to make two substantive amendments to the charges and to correct the anonymity of the service users mentioned in the Schedules.

Ms Girven proposed the following charges and schedules, namely charge 16 and the wording of Schedule E (3). Ms Girven said that the anonymity of service users would be corrected in the following Schedules: D(1), F(1, 2, 3, 4), G(2,3,4,7,8,9,10,11,12,13,14,16,18,19,20), H(2,5), J(1,2,3,5,), K(1,2,3,4), L(1,2,3,4), M(1,3,4,5,7,8,9), N(2,3), O(6,7,8), P(1), Q(3,4,6), R(4,5,6,7) and to correct a typographical error in Schedule R (2a).

Ms Girven submitted that the amendments are required for the anonymity to be consistent in the case and no disadvantage would be caused to you as this change is administrative.

However, Ms Girven submitted that the amendment to Charge 16 would be a substantial change as the regulation mentioned in the charge does not relate to the CQC. She said that Witness 3 confirmed this during her evidence and mentioned what the correct regulation should be. Ms Girven said that the suggested amendment is fair and without it, the charge does not make sense.

In respect of Schedule E(3), Ms Girven submitted that this was a significant amendment to the original charge in order to make the words reflect what was within the evidence matrix in relation to Witness 2's evidence. She submitted that the wording for Schedule E(3) is not found under regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA) but under regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014. However, it seems that the evidence provided deals with a variety of issues under Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014 and the charge should be amended to reflect this. Ms Girven submitted that this would be a fair amendment to make, and no prejudice or injustice would be caused to you. Ms Girven said that the year of the regulation was also incorrect and needed to be corrected as this was a typographical error. It was submitted by Ms Girven that the

proposed amendments would provide clarity and more accurately reflect the evidence before the panel.

The proposed amendments were as follows:

"That you, a registered nurse:

16) Failed to ensure that you/the Home notified the CQC of notifiable incidents and/or complied with regulations 18~~(5) (b) (11) of the Health and Social Care Act 4 2008 (Regulated Activities) Regulations 2014~~: **of the Care Quality Commission (Registration) Regulations 2009**

SCHEDULE D 5) Failed to ensure that services delivered/provided at the Home were responsive to the service users needs		
	Service User	**Event**
1	A,~~I~~ **J** & H	Did not ensure that one, or more, service user(s)were consulted when their care plans were reviewed/updated

SCHEDULE E 18)Failed to ensure that services delivered/provided at the Home were well-led/supervised:		
	Service User	**Event**
1		Did not ensure that robust quality checks were undertaken/shortfalls in service quickly remediated

2		Did not ensure that that the Accessible Information Standard 2016 was appropriately met
3		~~Did not ensure that the Home accommodation met the standards of~~ **Failed to assess, monitor and improve the quality and safety of the services in line with** regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 20~~04~~**14**

SCHEDULE F		
19) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014		
	Service User	**Event**
1	~~G~~ **N**	Did not adequately investigate allegations brought to you attention by Kent County Council that on, or around 22 October 2019, that Staff Member 2 has been speaking to Service User ~~G~~ **N** in an offensive/threatening/sexual manner
2	~~G~~ **N**	Did not limit or supervise contact between Staff Member 2 and Service User ~~G~~ **N**, following allegations of abuse being brought to you attention by Kent County Council on, or around 22 October 2019 and/or 5 November 2019
3	~~C~~ **K**	Did not adequately investigate allegations of abuse made by Service User ~~C~~ **K** against Staff Member 2

4	~~C~~ **K**	Did not report allegations of abuse raised by Service User ~~C~~ **K** against Staff Member 2 to (a) the CQC and/or Kent County Council

SCHEDULE G

20) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

	Service User	**Event**
1		Did not ensure that any and/or all of Staff Members 1, 2, 3 and 4 knew the correct fire procedures and/or how to follow the Personal Emergency Evacuation Plan ('PEEP') for one, or more, service users
2	~~A~~ **D**	Did not ensure that the information in the service users PEEP was complete/accurate
3	~~B~~ **J**	Did not ensure that the information in the service users PEEP was complete/accurate
4	~~C~~ **K**	Did not ensure that the information in the service users PEEP was complete/accurate
5		Did not ensure that one, or more, members of staff attended a fire drill at least every 3 months
6		Did not endure that ongoing checks of the Home's emergency lights were undertaken as appropriate
7	~~D~~ **L**	Did not ensure that Service User ~~D~~ **L** and/or other services users with reduced mobility were assisted to transfer safely and/or with the assistance of at least 2 members of staff
8	~~D~~ **L**	Did not ensure that an appropriate/full-body sling was used for Service User ~~D~~**L** when transferring to the toilet

9	~~A~~ **D**	Did not ensure that an appropriate/'in situ' sling was used for Service User ~~A~~**D**
10	~~C~~ **K**	Did not ensure that staff encouraged Service User ~~C~~**K** to change position in bed and/or that consistent arrangements were undertaken by staff to do so
11	~~B~~ **J**	Did not ensure that staff encouraged Service User ~~B~~ **J** to change position in bed and/or that consistent arrangements were undertaken by staff to do so
12	~~C~~ **K**	Did not ensure that appropriate instructions/processes were in place to provide appropriate/safe catheter care for Service User ~~C~~**K**
13	~~C~~ **K**	Did not ensure that Service User ~~C~~**K** was consistently supported to eat and drink safely
14	~~B~~ **J**	Did not ensure that Service User ~~B~~**J** was consistently assisted to sit in an upright position when eating and drinking to reduce the risk of choking
15		Did not ensure that staff were provided with written/appropriate guidance about providing emergency first aid if a service user choked
16	~~D~~ **L**	Did not ensure that one, or more, staff were aware/followed Service User ~~D~~**L**'s care plan in relation to their cheese allergy
17		Did not ensure that medicines were managed safely
18	~~E~~ **M**	Did not ensure that the administration of Hydroxocobalamin to Service User ~~E~~**M** between 26 November 2019 and 22 December 2019 was countersigned
19	~~E~~ **M**	Did not ensure that Service User ~~E~~**M** received the correct dose of Oxypro (5mg) and/or the correct dose was accurately recorded on: a) 9 December 2019; b) 14 December 2019
20	~~B~~ **J**	Did not ensure accident forms/reports were accurately completed in respect of Service User ~~B~~**J** in relation to incidents on:

		a) 16 November 2019; b) 19 November 2019

SCHEDULE H

21) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1		Did not consistently ensure that a sufficient number of staff members were working on shifts to meet the needs of service users
2	~~G~~ **N** & ~~H~~ **A**	Did not ensure that staff were available on 19 December 2019 to timeously assist: a) Service User ~~G~~ **N**; b) Service User ~~H~~ **A**
3		Did not ensure that one, or more, staff members were adequately supervised and/or such supervision was adequately recorded;
4		Did not ensure that one, or more, staff members, including Staff Members 1, 2 3 and 4 had all the knowledge and skills need to consistently provide safe care/care in line with national guidance
5	~~A~~ **D**	Did not ensure that staff were given guidance in care plans and have the competencies needed to consistently support Service User ~~A~~**D**'s needs arising from dementia

SCHEDULE J

10) Failed to ensure that the Home was meeting the nutrition and hydration needs of service users and/or complied with regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	Event
1	~~B~~ **J**	Did not ensure that accurate records were kept for meals taken by Service User ~~B~~ **J** on one, or more, occasion between 16 December 2019 and 22 December 2019
2	~~C~~ **K**	Did not ensure that accurate records were kept for meals taken by Service User ~~C~~ **K** on one, or more, occasion between 16 December 2019 and 22 December 2019
3	~~D~~ **L**	Did not ensure that accurate records were kept for meals taken by Service User ~~D~~**L** on one, or more, occasion between 16 December 2019 and 22 December 2019
4	F	Did not ensure that that one, or more, staff members knew about/recorded the target amount of fluid for Service User F
5	~~I~~ **O**	Did not ensure that that one, or more, staff members knew about/recorded the target amount of fluid for Service User ~~I~~ **O**

SCHEDULE K

11) Failed to ensure that the Home was adequately complying with the consent to care requirements of service users and/or complied with regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	Event
1	~~G~~ **N**	Did not ensure that suitable provision had been made to obtain consent in line with the Mental Capacity Act 2005

2	~~A~~ **D**	Did not ensure that an assessment was completed to see if Service User ~~A~~ **D** had the mental capacity to consent to sharing a bedroom
3	~~I~~ **O**	Did not ensure that relatives and/or healthcare professionals were consulted in relation to Resident ~~I~~**O** who was regularly encouraged to have bed rest in the afternoon
4	~~D~~ **L**	Did not ensure a condition relating to a review as to whether Service User ~~D~~ **L** should be resuscitated was completed/recorded
5		Did not know whether conditions were imposed on one, or more, authorisations under the Mental Capacity Act 2005 and/or ensure that Staff Members 1, 2, 3, 4 and/or 5 were aware of such conditions

SCHEDULE L

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	~~I~~ **O**	Did not ensure that Staff Member 3 communicated/engaged with Service User ~~I~~**O** appropriately when assisting them with eating on 19 December 2019
2	~~H~~ **A**	Did not ensure that Staff Member 4 promoted the privacy/ dignity of Service User ~~H~~ **A** when using the toilet on 19 December 2019
3	~~D~~ **L**	Did not ensure that Staff Member 4 promoted the privacy/ dignity of Service User ~~D~~**L** when using the toilet on 19 December 2019

4	~~I~~ **O**	Did not ensure that Staff Member 4 supported Service User ~~I~~**O** in actively making a decision as to whether to go to their bedroom or remain in the lounge on 19 December 2019
5		Did not ensure that and and/or all of Staff Members 1, 3, 4 and 5 were able to communicate effectively with service users
6		Did not ensure that one, or more, service user with mental capacity were provided with a key to lock their bedroom
7		You did not develop links with local lay advocacy resources and/or understand the need to do so

SCHEDULE M

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	~~C~~ **K**	Did not ensure that Service User ~~C~~ **K** was involved/consulted in relation to their care plans in, or around, 3 months prior to the inspection on 19 December 2019
2	F	Did not ensure that Service User F was involved/consulted in relation to their care plans in, or around, 3 months prior to the inspection on 19 December 2019
3	~~A~~**D**	Did not ensure that the reviews of Service User ~~A~~**D**'s care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019
4	~~E~~ **M**	Did not ensure that the reviews of Service User ~~E~~ **M**'s care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019

5	~~I~~ **O**	Did not ensure that the reviews of Service User ~~I~~**O**'s care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019
6		Did not ensure that information was presented to one, or more, service user in an accessible manner and/or as required by the Accessible Information Standard 2016
7	~~D~~ **N**	Did not ensure that Service User ~~D~~ **N** was appropriately assisted by Staff Member 3 in relation to their food choice in, or around December 2019
8	~~D~~ **L**	Did not ensure that Service User ~~D~~**L** was appropriately supported to access support/activities during the period 19 November 2019 and 3 December 2019
9	~~I~~ **O**	Did not ensure that Service User ~~I~~**O** was appropriately supported to access support/activities during the period 19 November 2019and 3 December 2019

SCHEDULE N

14) Failed to ensure that the Home effectively received/handled complaints and/or complied with regulations 16(1) and 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1		Did not ensure that your complaints policy and procedures were accessible to one, or more, service users
2	~~C~~ **K**	Did not ensure that Service User ~~C~~**K**'s complaint relating to food between September 2019 and November 219 was appropriately investigated and/or resolved
3	~~I~~ **O**	Did not ensure that a complaint on behalf of Service User ~~I~~**O** relating to wheelchair positioning between September 2019

		and November 2019 was appropriately investigated and/or resolved

SCHEDULE O

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1		Did not ensure that robust systems and processes to assess monitor and improve the quality and safety of the service were established as at 19 December 2019
2		Did not ensure that adequate audit relating to medicines management were undertaken as at the date of the inspection on 19 December 2019
3		Did not ensure that service users were consulted regarding the development of the service
4		Did not ensure that any and/or all of Staff Members 1, 2, 3, 4 and 5 were suitably supported/trained to understand their responsibilities and provide safe and effective care
5		Did not ensure that effective 'handover' of care was provided/implemented
6	~~C~~ **K**	Did not ensure that the care plan audit completed on 20 May 2019 identified/addressed shortfalls relating to arrangements for Service User ~~C~~**K** to drink safely
7	~~D~~ **L**	Did not ensure that the care plan audit completed on 20 May 2019 identified/addressed the unsafe practice relating Service User ~~D~~**L** being transferred by hoist

8	~~A~~ **D**	Did not ensure that the care plan audit completed on 27 December 2019 identified/addressed the need for Service User ~~A~~**D** to be transferred using an 'in-situ' sling

SCHEDULE P

16) Failed to ensure that you/the Home notified the CQC of notifiable incidents and/or complied with regulations 18(5) (b) (11) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	~~G~~ **N**	Did not notify the CQC of allegations brought to you attention by Kent County Council that on, or around 22 October 2019, that Staff Member 2 has been speaking to Service User ~~G~~**O** in an offensive/threatening/sexual manner
2		Did not notify the CQC of Staff Member 2's dismissal

SCHEDULE Q

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council, as at the date of the inspection of 30 May 2019

	Service User	**Event**
1		Did not ensure that the Home was free from trip hazards, in that there was a hole in the floor and/or the carpet needed replacing
2	~~J~~ **M**	Did not ensure that Resident ~~J~~ **M**'s care plan provided appropriate information in relation to: a) SALT/diet and risk of choking; b) Hearing;

		c) Skin integrity
3	~~K~~ **J**	Did not ensure that in relation to Resident ~~K~~ **J**: a) their falls record consistently matched the accident recordings log within the Home; b) a self- harming risk assessment was in place; c) their eating and drinking SALT Guidelines were included in their care plans
4	~~L~~ **O**	Did not ensure that in relation to Resident ~~L~~ **O**: a) their care plan reflected the occupational therapy recommendation; b) their care plan reflected how their skin integrity should be managed
5		Did not ensure that one, or more, resident's daily notes were reflective of the choices offered to them and/or showed how each resident's day looked on any given day
6	~~K~~ **J**	Did not ensure that appropriate actions/responses were undertaken and/or recorded in relation to Resident ~~K~~ **J**, who had slipped off of their chair 4 times between September and December 2018
7		Did not ensure that one, or more accident/incidents were accurately/appropriately recorded
8		Did not ensure that the Deprivation of Liberty ('DoLS') tracker was kept up to date
9		Did not ensure that one, or more, residents had their own room and/or the reasons for any residents who shared a room were recorded
10		Did not ensure that one, or more, smoke detectors were replaced/working between 15 February 2019 and 30 May 2019

SCHEDULE R

Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council, as at the date of the inspection on 22 October 2019		
	Service User	**Event**
1		Did not ensure that one, or more, items of the Action Plan following the inspection of Kent County Council on 30 May 2019 were completed
2		Did not ensure that one, or more, of the following environmental safety concerns were addressed: a) rubbish piled in the garden and/or bins at the front of th**e** Home overflowing; b) Safe use of extension leads/electrical systems; c) Split wheelchair cushions posing an infection risk;
3		Did not ensure that one, or more, of the following health and safety concerns were addressed: a) Fire door being propped open with objects and furniture; b) The condition of the shower room;
4	~~M~~ **D**	Did not ensure that the resident's care file(s) were complete and/or accurate and/or consistent
5	~~N~~ **K**	Did not ensure that the resident's care file(s) were complete and/or accurate and/or consistent
6	~~N~~ **K**	Did not ensure that one, or more, of the daily care notes contained appropriate detail and/or was legible, including: a) Resident ~~N~~ **K**
7	~~M~~ **D**	Did not ensure that appropriate care was provided to one, or more residents including: a) Resident ~~M~~ **D** in relation to supervision whilst eating; b) 5 additional residents who were observed unsupervised during lunch

8		Did not ensure that a new carer spoke to a resident who was unsettled in an appropriate way on 22 October 2019
9		Did not ensure that appropriate/suitable activities were available for the residents at the Home
10		Did not ensure that appropriate steps to meet the dietary needs of one, or more, residents

You indicated that you had no objections to the proposed amendments.

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

The panel determined that the amendments to charge 16 and the correction of the service users within Schedule (s) D, F, G, H, J, K, L, M, N, O, P, Q and R were fair amendments to make. Such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy in the charges.

In respect of Schedule E(3), Ms Girven had directed the panel to paragraph 75 of Witness 2's witness statement and had identified that the amended wording came from this paragraph. The panel determined that the suggested amendment would effectively change the nature of the allegation:

> ~~Did not ensure that the Home accommodation met the standards of~~ **Failed to assess, monitor and improve the quality and safety of the services in line with** regulation (sic) 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 20~~04~~**14**

This proposed amendment was major, and applied for late in the day, after all the NMC witnesses had given evidence especially the relevant witness who the NMC were relying upon for this charge.

This is unfair to you as the change in wording of Schedule E(3) would raise different concerns to those as set out in the original allegations. The panel determined that, as the registrant, you should be able to see the charges and understand the allegations put before you to enable you to address them properly. It noted that amending the wording in Schedule E(3), would change the allegation entirely and would therefore cause prejudice to you. Taking everything into consideration, the panel rejected Ms Girven's application to amend Schedule E(3).

Decisions and reasons on a further application to amend a charge

When resuming the hearing on Thursday 27 March 2024, the panel of its own volition wanted to make an amendment to Charge 19c, this was to accurately reflect what Manager 1 said in his evidence and in his witness statements that he overheard a conversation during handover.

The original charge reads as follows:

19) Having left the Home without qualified nursing cover/staffing on 6 October 2019 as referred to in charge 18 above, you:

c) On, or around, 7 October 2019, said to Manager 1 words to the effect that HCA 1 had gone to fetch Patient A;

The proposed amendment is as follows:

19) Having left the Home without qualified nursing cover/staffing on 6 October 2019 as referred to in charge 18 above, you:

c) On, or around, 7 October 2019, said ~~to~~ **in the presence of** Manager 1 words to the effect that HCA 1 had gone to fetch Patient A;

The panel was of the view that such an amendment would accurately reflect the evidence that it had before it and was in the interests of justice. The panel was satisfied that there would be no prejudice to you or the NMC and no injustice would be caused by the proposed amendment being made.

Ms Girven submitted that the NMC support the amendment as suggested.

You said you supported the application.

The panel therefore determined that it was appropriate to make the amendment as suggested to include the additional wording in Charge 19c.

Decision and reasons on disputed 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 Girven on behalf of the NMC and by you.

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

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

- Witness 1: Commissioner for Kent County Council who visited Abbey Care Court Home.
- Witness 2: Former CQC inspector who inspected Abbey Care Court Home.

- Witness 3: Inspection Manager in the Adult Social Care Inspection Directorate of the CQC.

- Witness 4: Commissioner for Kent County Council who visited Abbey Care Court Home.

- Witness 5: Manager 1 at [Private] the Unit.

- Witness 6 (HCA 1): HCA 1 at [Private] the Unit.

The panel also heard evidence from you under affirmation.

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

The panel's approach in considering the witness and documentary evidence was to consider first any agreed evidence, and any known facts arising from the documentary evidence. It considered each individual charge, and all the evidence presented in relation to each.

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

Charge 1a (Schedule A) (1)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**

1	A	Did not have in place robust arrangements to manage and support the resident's condition of diabetes

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection along with a report attributed to Ms 1 that is unsigned and undated. It also took account of your evidence.

The panel noted that this concern was identified during the CQC inspection visit of the Home on 17 December 2018 where Witness 2 was the lead inspector. Witness 2 attended the Home with Ms 1 who was a special professional advisor and Ms 2 who was an expert by experience. Neither Ms 1 nor Ms 2 were called to give evidence in your case by the NMC nor did they provide witness statements.

At the outset of Witness 2's oral evidence he was taken to his two witness statements and stated:

> *'… I have no recollection of making either of these statements.'*

When Witness 2 was asked about his signature on his statement dated 12 July 2019, he stated:

> *'It's a version of my signature, yes, yeah. But I will -- am I allowed to point out that being in* [PRIVATE] *I presume I signed this signature, the Council has taken two years to deal with this case and in those two years I have lost all recollection of the fact … that I'd signed this document, presumably written this document and I have no recollection about the contents of it whatsoever.'*

Witness 2 was then asked whether he would have signed the statement of truth if he did not believe it was true. He responded,

‘A. Obviously not. Obviously not but I must emphasise again, to the hearing, I have no recollection of this document whatsoever and in fact when I was told that I had written this document I was very surprised because I have no recollection of it after two years. Therefore, I can't comment on it.’

Witness 2 was asked about his statement dated 29 January 2021 and stated:

‘Q. … This is a second witness statement that you produced. At the bottom of that page, there is signature. Do you recognise that signature?
A. I do, yes, that's my signature
Q. Again, can you see there is a declaration of truth at the bottom?
A. Yes, yes.
Q. Would you have signed that if that was not true?
A. Presumably not.
Q. Thank you.
A. I have no recollection of this document at all.’

When questioned by the panel regarding his signature, Witness 2 stated,

‘A*. No, to be fair, I think it was my signature’.*

In relation to his witness statements, Witness 2’s evidence to the panel was that the CQC edited them and that there were mistakes within them. In particular, in relation to the 2018 inspection, Witness 2 said that the CQC told him to put in his statements that you did not offer a specific response when shortfalls were brought to your attention.

With specific regard to the witness statements before this panel, Witness 2 said:

‘Q. Is it possible that these statements were made without input from the CQC?
A. No, it's not possible because that's not how CQC works. Individual officers don't have the authority to write a statement to an outside regulator without it being checked.’

Witness 2 in his witness statement stated,

> '*[Service User A] care records were examined by* [Ms 1]*, being the specialist professional advisor. We do not have a copy of the original clinical notes which were reviewed'.*

It was further mentioned by Witness 2 in his statement:

> *'Although I did not review* [Service User A] *notes myself, I share* [Ms 1's] *concerns as it relates to* [Service User A].*'*

When asked questions about this allegation during his evidence,

Witness 2 stated that '*A. I have no recollection of that matter at all, I am sorry'.*

In relation to the December 2018 inspection, Witness 2 said that he did not remember the inspection at all.

In relation to preparing to attend for inspection, Witness 2 told the panel that comments were made by other people within CQC that were personal to you:

> *'Q. You quoted some of the language that was used, can you tell us names for those people? Were they in meetings, were they one-to-one with you personally? Did you see it written down?*
> *A. No, I mean, so I wish I could give you names but I think it would be unfair just to quote names who I think the most likely because these comments were grossly offensive to Ms Persand and totally untrue. It was conversations in staff meetings, sort of in between presentations, conversations in corridors, I heard. Someone may have come up to me and said, "I hear you're going to Abbey Court, that's Ms Persand, she's a problem. She should be running a corner store rather than running a care home", which is a grossly offensive racist statement to make. "She's lazy, she's incompetent", all the things like that. I put those out of my head because I'm not willing to listen to that*

nonsense. My job was just to go there and to implement the methodology, in special methodology and I put that out of my head. I can say that there was a sort of visceral campaign against Ms Persand in CQC. I know that's hard to accept because it's a formal organisation and regulator. But that was my experience, there was a visceral campaign of victimisation against Ms Persand.'

When asked by the panel if he stood by the contents of the 2018 inspection report, Witness 2 said:

'It is difficult to stand by something in the sense that I -- because I do have these problems with my memory, they're genuine problems. And it's difficult to stand by something that I don't have any real recollect of the detail, the evidence of almost the inspection report was based…'

Furthermore, Witness 2 gave evidence that the CQC was an *'out of control regulator.'*

With regard to the information provided by Ms 1, Witness 2 said:

'she's a registered nurse, she used to be an inspector for CQC, and (Inaudible) she was a specialist professional adviser. Her job, I think, was to look at the meds administration. I sort of accepted it because I hadn't looked at the evidence so that was her job to look at the evidence and to come to a judgement and so really if you want to know more about that particular sentence, you would need to talk to Ms 1 about it.'

You told the panel:

'… I mean, bearing in mind it's a long time ago and I do not have any of the files of the nursing home. When the nursing home was closed in March 2020, I was told, "Do not remove anything from the premises". So I do not have any files, any folders to back up my evidence. So all I'm going to refresh my memory is to think back at all the charges. That's all I can do. I don't have any

written evidence, any folders to prove that these are correct or is not correct.' [sic]

During your oral evidence you informed the panel that Service User A was pre-diabetic and not diabetic and was therefore on diet control and not on any medication. Service User A was managed in accordance with the General Practitioner's (GP) advice.

The panel was not able to rely on the evidence provided by Witness 2 in relation to this charge. He could not recollect the 2018 inspection at all and undermined his witness statement in that he said it was checked by the CQC and that he was instructed by them to add sections to it.

It was clear from his oral evidence that Witness 2 had no faith in the process of the production of the 2018 inspection report or his NMC witness statements, and that he was disparaging of the CQC as an organisation. He raised serious concerns about the impartiality of other personnel at the CQC in relation to you.

The panel determined therefore that it could place little weight on the evidence provided in his statements and within the 2018 inspection report.

In relation to Ms 1's report, the panel could not rely upon it, given she did not attend to give evidence, and therefore her evidence was not tested. Witness 2's evidence in relation to that report was that he accepted it but had not looked at the evidence himself. The panel determined it was unreliable.

As a result of the conflicting information before it, and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. The panel therefore finds this charge not proved.

Charge 1a (Schedule A) (2)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

2		No record of equipment checks/checks that equipment was set to the correct pressure for one, or more, service users

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection along with a report attributed to Ms 1 that is unsigned and undated. It also took account of your evidence. There were no documents or records provided to the panel to support this allegation.

You told the panel that there were records but you no longer had access to them. During cross examination by Ms Girven, you said:

> *'Q. It wasn't recorded when the mattresses had been checked?*
> *A. ...there was a record. To my recollection, it says pressure mattress check, all working in order. We won't be recording every single hour pressure mattress 12.5, pressure mattress 16.5. There was a range … by the bed, what range it should be. So what the carer or whoever attended that client will check when they're finishing washing the clients, it's there. They will check. So it says there in the notes. Well, they had like a form to fill in in their notes separate to … in the file itself we said this lady was washed this morning, pressure mattress check tick...'*

The panel has borne in mind its conclusion on Witness 2's evidence including Ms 1's report as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof.
The panel find this charge not proved.

Charge 1a (Schedule A) (3)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

3	B	The records examined for the resident showed that the service user was only assisted repositioned 3 times per day, whereas their skin integrity plan stated that the service user should be repositioned every 2- 3 hours

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection along with a report attributed to Ms 1 that is unsigned and undated. It also took account of your evidence.

The NMC did not rely on Service User B's care records in support of this charge. The evidence the NMC relies upon was Witness 2's. As previously mentioned, Witness 2 questioned the reliability of his own witness statements and effectively undermined his own evidence. The panel could not place much weight on the evidence it had before it. Ms 1 who reviewed Service User B's records was not present at the hearing to give evidence. The panel had sight of Ms 1's unsigned and undated report, which Witness 2 references in his witness statement.

In your oral evidence you stated that Service User B was repositioned, that this would have been recorded in Service User B's daily notes and there was a system in place to ensure it was recorded.

The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof.

The panel find this charge not proved.

Charge 1a (Schedule A) (4,5 and 6)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

4	C	No guidance provided in relation to the administration of paracetamol for pain relief
5	A	No guidance provided in relation to the administration of Senna for constipation
6	D	No guidance provided in relation to the administration of Zapain for pain relief

These charges are found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection along with a report attributed to Ms 1 that is unsigned and undated. It also took account of your evidence.

The panel noted that the CQC in its report identified that there were protocols regarding PRN (*pro re nata*, medication given as required) administration in place for service users. However, it stated that these protocols were not detailed and were inadequate. The panel did not have sight of the PRN protocols for Service Users C, A and D. Due to Witness 2 undermining the reliability of his own evidence, the panel could not place much weight on what was stated. The shortfall regarding the PRN protocols were identified by Ms 1, who was not present at this hearing.
The panel determined that the NMC had not discharged its burden of proof. It therefore finds these charges not proved.

Charge 1a (Schedule A) (7)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

7	A	Did not have in place a process for safe medication stock management and/or ensure that such a process was followed

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection along with a report attributed to Ms 1 that is unsigned and undated. It also took account of your evidence.

Witness 2 in his statement stated:

> *'It was also found that the nurses had not carefully checked the stock of some medicines. The concern came to light as part of* [Ms 1's] *examination of the service's medicines management arrangements. I did not see the records referred to by* [Ms 1] *and I am not in possession of the relevant drug record which indicates that there was a discrepancy in the medication.'*

The panel had not been provided with the relevant records.

You told the panel that there was a policy in place for medication management.

The panel has borne in mind its conclusion on Witness 2's evidence including Ms 1's report as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof.

The panel find this charge not proved.

Charge 1a (Schedule A) (8)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

8		Did not ensure that service users were fully/adequately protected from the risk of fire

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection along with the Factual Accuracy Comments Form which you completed on 24 January 2019, and the Remedial Action Plan February 2019 which you submitted to the CQC.

The panel considered that Witness 2 in his witness statement stated that he had '*witnessed the obstruction directly'*. When questioned Witness 2 told the panel:

> *'Q. Do you accept if you have recorded in your statement that the* [sic] *were concerns about fire safety that it is likely that that there were concerns?*
>
> *A. It appears from this that there were some concerns. I note that they can't have been particularly serious concerns because otherwise we would have passed the Home over to the Kent Fire and Rescue Service. We would have made a referral to the Kent Fire and Rescue Service, and I don't think I can see that here'.*

The panel considered that you had also made the following comments on the Factual Accuracy Form:

> *'The manager did inform the inspector that the obstruction she identified in her risk assessment will be removed and this has not been added to the report.'*

The panel also noted that on the Remedial Action Plan dated February 2019 it appears that the obstruction blocking the fire exit during the CQC inspection was removed and this task was marked as completed on *'08.02.19'.*

The panel noted that both the Factual Accuracy Form and the Remedial Action Plan supported the account provided by Witness 2 in his statement and oral evidence.

The panel therefore determined that on the balance of probabilities you did not ensure that service users were fully/adequately protected from the risk of fire. It therefore finds this charge proved.

Charge 1a (Schedule A) (9)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

9		Did not ensure that the Home was being cleaned to suitable standard to promote good hygiene/prevent and control the risk of infection

This charge is found NOT proved.

In reaching its decision the panel considered Witness 2's witness statements and oral evidence.
Witness 2 when questioned by Ms Girven made the following comments:

> *'Q. Can you remember anything about the general maintenance of the Home?*

A. The maintenance of the Home was very good. There can be no question about that, the Home was clean, was well decorated, it was warm. And there was no issues at all about the maintenance of the service.

….

Q. … Do you accept that there were concerns about the cleanliness of the Home?

A. No, I don't. Obviously, there's these three issues. I don't sort of recall them at all...'

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof.

The panel finds this charge not proved.

Charge 1a (Schedule A) (10)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

10		Did not have a formal/appropriate system was used to ensure that sufficient levels of staff were on duty

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection.

The panel noted that the only direct evidence for this charge came from Witness 2. The inspection report identified that there was no written documentation regarding staffing levels.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof.

The panel finds this charge not proved.

Charge 1a (Schedule A)(11)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

11		Did not ensure that adequate background checks were undertaken for one, or more, members of staff

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection. It also considered your own oral evidence.

The panel noted that concerns were raised regarding the background checks of the Home's staff. Witness 2 in his statement stated that you failed to obtain a full and continuous account of the applicants' respective periods of employment. Within the same witness statement, Witness 2 stated:

'*However, despite the above concerns it was found that the Registrant had obtained the required references for these employees and had obtained clearance from the Disclosure and Barring service.'*

You told the panel:

'I always checked to make sure they have the right documents before they start working in Abbey Court…'

When asked about gaps in their employment you said:

'A. And I would record it on the application form itself. Or we always request for a CV, so it'll be recorded on the CV…

…

A. Of course, some people might want to have a break in between, so there is no employment. So which mean some people might, for example, giving -- having to look after their family. So there will be a gap when there's no employment involved. But this doesn't mean that the question hasn't been asked.'

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof.

The panel therefore finds this charge not proved.

Charge 1a (Schedule A) (12)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

12		Did not ensure that a hole in floor of the corridor covered by a mat was repaired timeously

This charge is found NOT proved.

In reaching its decision the panel took into account the evidence of Witness 1 and a copy of the Inspection report from Kent County Council dated 30 May 2019.

Witness 1 in her witness statement stated:

> *'<u>Environmental Concerns</u>*
> *9. There was a hole in the floor in the corridor which was being covered by a mat. It was determined that both the mat and the hole posed a trip hazard to the residents and that the carpet needed to be replaced.'*

Witness 1 in her oral evidence stated:

> *'So I'd sort of picked up the mat, but then there was sort of like a dip in the floor, in the middle of the mat. I think from memory, like I said, it was quite a long time ago, it was kind of like, you know, it was like a cement floor and some of the layers had come away. I mean, size wise, that sort of size, that sort of deep. It was Mrs Persand who got it repaired.*
>
> *Q. Thank you. Just for the sort of purposes of the recording, really. Would you be able to estimate when you -- you showed us with your hands –*
> *A. I'm very good at … I don't know, 15 centimetres maybe.*[sic]*'*

The panel found that Witness 1 was consistent in her evidence that there was a hole that was repaired by you, however she was not able to assist with when the work was carried out or how long there had been a hole.
Whilst the panel accepted that there had been a hole in the floor at some time, it could not ascertain how long it had been there and when you had repaired it.

Furthermore, the panel found the charge to be unclear in relation to what was meant by ‘timeously’. Therefore, the panel could not determine whether you repaired this hole ‘timeously’.

This charge is found not proved.

Charge 1b)

1) Failed to ensure that care and treatment was provided in a safe way for service users and/or ensure that the Home complied with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *‘generally’*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC’s case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask

questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

The panel therefore finds this charge not proved.

Charge 2a (Schedule B) (1)

2) Failed to ensure that the services delivered/provided at the Home were effective/delivered in an effective manner

	Service User	**Event**
1		Did not ensure that one, or more, members of staff were fully supported/received training and guidance to support service users who were living with dementia

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection.

The panel noted that Witness 2 raised the concerns regarding the training of staff at the Home. Within his witness statement he mentioned:

> *'…Staff training records showed that members of staff had taken introductory training as well as more detailed training in a range of areas including supporting and responding to service users with dementia. However, I was told directly by three members of the care staff that they would like more training and guidance as it related to supporting people who were living with dementia.'*

Witness 2 in his oral evidence, reiterated what was mentioned in his witness statement.

> *'A. … I cast my mind back these … three members of staff they would like to have more training in this particular area. I mean I have to say for the benefit of the panel that there is nothing in the regulations that says that members of staff have to have training. It's one of those paradoxes, (Inaudible) regulation says that …, "Staff have to be competent in these subject areas". There was no indication that as far as I can recall that the staff weren't competent. Now, these three members of staff where they said that they would like to have more training in this particular subject, but I think the thing to focus on is the fact that unlike in many homes they had had some training already. They had had introductory training and ongoing training and I just wished that was the case for other care homes. In fact, this particular care home had given more training in the subject than some other care homes.'*

In your oral evidence you stated that staff always had dementia care training and that there were staff training records.

The panel were not provided by the NMC with any staff records to show whether or not staff received training in dementia care.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof.

The panel finds this charge not proved.

Charges 2a (Schedule B) (2) and (3)

2) Failed to ensure that the services delivered/provided at the Home were effective/delivered in an effective manner:

2	D	Did not ensure that suitable support arrangements/training was in place to support this service user who had dementia
3	E	Did not ensure that suitable support arrangements/training was in place to support this service user who had dementia

Charges 2a (Schedule B) (2) and 2a (Schedule B) (3) found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection.

Witness 2's evidence was the only evidence relied upon for this charge by the NMC.

The panel bore in mind its findings in relation to Charge 2a (Schedule B) 2) 1)). The NMC did not rely on Service User D and E's care plans or other records in support of these charges.

The panel noted that Witness 2 in his evidence stated that staff at the Home had been trained by way of induction and more detailed training was given to assist them to support service users with dementia. He was also of the opinion that different staff members interacted with service users in different ways and acknowledged that this was not always consistent, but stated this in itself was not a serious concern.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate these charges, the NMC have failed to discharge its burden of proof.

The panel finds these charges not proved.

Charge 2a (Schedule B) (4)

2) Failed to ensure that the services delivered/provided at the Home were effective/delivered in an effective manner

4		Did not ensure that the Home accommodation was designed/adapted/decorated to meet the needs of service users and/or comply with regulation 15(1)(c) and (e) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2004

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection, Witness 3's evidence, including her witness statement which exhibited the CQC inspection report dated 29 June 2015 and the CQC inspection report dated 28 June 2017.

Witness 2 gave direct evidence in his witness statement regarding the Home's accommodation. However, in his oral evidence he stated that the Home was clean, well decorated and warm, which contradicted his written statement and reports.

The NMC relied upon two CQC inspection reports dated 29 June 2015 and 28 June 2017 exhibited by Witness 3 in support of this charge. However, within Witness 3's statement she stated that she was not involved in these inspections, nor did she know who the authors were. These inspection reports were admitted as hearsay evidence on the basis that they would not be the sole and decisive evidence.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. As a result, the inspection reports which were hearsay exhibited by Witness 3 by default became the sole and decisive evidence in relation to this charge. The panel could not place much weight on these inspection reports, given the untested nature of the evidence they contained.

The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof.

The panel finds this charge not proved.

Charge 2b

2) Failed to ensure that the services delivered/provided at the Home were effective/delivered in an effective manner:

    b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

The panel therefore finds this charge not proved.

Charge 3a (Schedule C) (1)

3) Failed to ensure that services delivered/provided at the Home were provided/delivered in a caring manner:

	Service User	**Event**
1		Did not ensure that staff used English as their first language/provided effective communication with service users

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection and the factual accuracy comments form. It also took account your evidence.

The panel noted that Witness 2 in his witness statement stated he had found there were concerns regarding staff and the use of the English language. However, in his oral evidence, Witness 2 stated that you had noticed there was an issue with the language barrier with staff and had arranged for staff members to attend an English course. Witness 2 said it "is very unusual in residential care services" for this to happen.

In the factual accuracy comments form you stated:

> '*Language barrier. There is a training programme in place to teach English to the carers and how can the inspector say it is poorly organised when he did not even have a look what was in place and how this training is delivered to the carers*'.

In your oral evidence you acknowledged there were issues with staff members not being fluent in English as it was not their first language, but that you had no concerns about their "language capabilities". You said your staff did not have a good level of English, but that they were able to communicate with clients, "adhere to their needs and they were able to respect their dignity". You reiterated that you had enrolled staff members onto an English course.

The panel found that you were consistent when explaining the concern regarding the English language and the training courses you had in place.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 3a (Schedule C) (2)

3) Failed to ensure that services delivered/provided at the Home were provided/delivered in a caring manner:

2	Unknown	Did not ensure that the service user received appropriate/ supportive care in their request to access the garden

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection. It also took account of your evidence.

The panel took account of Witness 2's statement, where he mentioned;

'…*we were also concerned that one service user was not receiving supportive care that promoted their dignity. This is because, the minutes of a 'residents' meeting that had occurred, showed that a service user had requested to have access to the garden. Based on the minutes which I reviewed, the Registrant's response to this was that it was, "quite unrealistic as they cannot walk". This response was disrespectful and did not address the service user's request. These meeting minutes has been written by the Registrant. We spoke to the Registrant regarding this and she accepted that more care was needed to be taken when responding to service users' requests to ensure that service users' dignity was not undermined.* [sic]*'*

In his oral evidence, Witness 2 was unclear in his response when addressing this question. He recollected that it was a cold day on the date of the inspection. However, the panel noted that this concern related to the minutes of a residents' meeting that had occurred prior to the inspection.

In your evidence you said you could not recall the specifics of the concern.

The panel also noted that it did not have sight of the minutes of this residents' meeting.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 3a (Schedule C) (3)

3) Failed to ensure that services delivered/provided at the Home were provided/delivered in a caring manner:

3		Did not ensure that one, or more, service user had access to keys to their bedroom doors

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection and the factual accuracy comments form. It also took account of your evidence.

Witness 2 in his statement mentioned a concern regarding service users not being offered privacy. Witness 2 stated;

> *'…none of the service users were able to recall being offered keys, but three of them stated that they would like to be able to lock their bedroom door. I raised this concern with the Registrant at the conclusion of our inspection visit, but my inspection notes do not state that the Registrant provided any specific response to these concerns.'*

You told the panel that when a resident moved into the home a decision was made with the resident and their family as to whether they would like a key.

In the factual accuracy comments form, you stated;

> *'The manager did not have any discussion about bedrooms' keys. Any service user requesting for a key is given one. We have evidence that one service user had a bedroom key during his stay at Abbey court nursing home.'*

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 3b

3) Failed to ensure that services delivered/provided at the Home were provided/delivered in a caring manner:

   b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

The panel therefore finds this charge not proved.

Charge 4a (Schedule D) (1)

4) Failed to ensure that services delivered/provided at the Home were responsive to the service users needs

	Service User	**Event**
1	A, J, & H	Did not ensure that one, or more, service user(s)were consulted when their care plans were reviewed/updated

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection. It also took account of your evidence.

The NMC did not rely upon the care plans for service users A, J and H in support of this charge.

The panel noted that there was documentary evidence in the form of care plans and other individual service user records for which the original service users' names had been redacted. The panel determined that it could not make assumptions about documents upon which the service user's names had been redacted and replaced with letters. This was because they did not always correspond to the amendments made in the charges to the letters assigned to service users.

Witness 2 in his statement stated that he spoke directly to service users A, J and H about their experience of contributing to decisions regarding their care. He stated that *'each of them stated to me that they were not aware of any care plan which had been developed on their behalf'.*

In your oral evidence when questioned, *'When a care plan was reviewed, did you always consult patients about that review?'* You answered '*definitely'.*

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 4a (Schedule D) (2)

4) Failed to ensure that services delivered/provided at the Home were responsive to the service users needs

2		Did not ensure that care plans / records were presented in an accessible manner

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection. It also took account of your evidence.

The NMC did not rely on any care plans or records to support this charge.

Witness 2 in his statement said,

> *'… based on the care records which I reviewed, I found that the requirements under this standard had not been met as care plans and care records did not present information in an easy-read format…. The records did not use signs, pictures, graphics or multi-media tools to present information in a way that was likely to be more accessible to service users with sensory adaptive needs who lived with dementia'.*

In your evidence you told the panel that care plans were presented in an accessible manner.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 4a (Schedule D) (3)

4) Failed to ensure that services delivered/provided at the Home were responsive to the service users needs

3		Did not ensure that social activities were appropriately managed and/or delivered and/or recorded

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's evidence, Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection and Abbey Court Nursing Home Social Activities Participation in November 2019. The panel also took account of Witness 3's evidence which included the CQC inspection reports relating to 24 November 2011 inspection, 5 and 9 March 2015 inspection, 29 June 2015 inspection, 7 and 8 April 2016 inspection, 16 and 17 March 2017 inspection, 7 November 2017 inspection, which were admitted as hearsay evidence. It also took account of your evidence.

Witness 1 in her witness statement stated that on 22 October 2019 Kent County Council (KCC) carried out their inspection at the Home. Witness 1 stated;

> *'We found that meaningful interaction and activities were seriously lacking in the Home.*
>
> *…*

We requested that a clear activity plan be put in place and that activities and interactions be recorded for each resident. We also requested that activities and interactions be recorded for those residents who were bed bound.'

Witness 1 in her oral evidence explained what type of activities KCC would have expected the Home to have provided to its residents. There was an expectation that the activities were recorded.

Witness 2 in his statement stated:

'I observed that the calendar of social activities was poorly managed, delivered and recorded. This led to the concern that service users were not offered sufficient opportunities to pursue hobbies and interest.
…
There were records of the activities each person had undertaken but the record from October 2018 onwards were not available...'

You told the panel the activities book was not available on the date of inspection in December 2018. You said in your evidence,

'*There was a part-time activity person in place. And also, on the days the activity person wasn't around, so the staff would be … doing the activities in the afternoon or morning. I can't recall on top of my head. But there was always some kind of activities in the home. Bearing in mind the people that we had left was ten people and they were elderly, frail. So they all have different activities session.'*

The panel noted that the CQC investigation reports exhibited by Witness 3 indicated that although there were some improvements over the years, there remained ongoing and persistent concerns about the programme of activities for residents, especially those with dementia.

When considering the facts of the case, the panel also considered what Witness 3 said about your management of the Home:

‘Q. How would you describe Mrs Persand's general approach to the management of the home?

A. Chaotic. Discussions with Mrs Persand were very difficult. Mrs Persand was very angry with, with KCC, she didn't quite -- she didn't agree with a lot of what we raised. I felt there was a real misunderstanding of what we were asking for, what we were expecting. There was a real -- it was a real struggle trying to get Mrs Persand to understand what we felt was good quality and what we were asking to be delivered. There was a frustration from both sides. You know, we were frustrated that improvements were minimal. And Mrs Persand was frustrated with Kent County Council. Discussions were difficult.’

The panel has borne in mind its conclusion on Witness 2’s evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2’s evidence. He undermined his own evidence. However, the panel noted that evidence from Witness 1 supported the concerns raised by Witness 2. The panel was satisfied that the oral evidence from Witness 1 was consistent with her witness statement. Witness 3 gave credible evidence about your general approach to the management of the Home, which the panel accepted. Although the historic reports exhibited by Witness 3 were hearsay, it was the panel’s view that they added supporting evidence.

The panel was satisfied that you did not ensure that social activities were appropriately managed and/or delivered and/or recorded. The panel therefore find this charge proved.

Charge 4b

4) Failed to ensure that services delivered/provided at the Home were responsive to the service users needs

   b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

The panel therefore finds this charge not proved.

Charge 5a (Schedule E) (1)

5) Failed to ensure that services delivered/provided at the Home were well-led/supervised:

	Service User	**Event**
1		Did not ensure that robust quality checks were undertaken/shortfalls in service quickly remediated

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection. It also took account of your evidence.

The panel considered the CQC inspection report for the December 2018 which stated the following:

> *'The registered manager completed a number of quality checks that were designed to ensure that the service consistently provided people with safe and responsive care. However, we noted that these checks had not been sufficiently robust to quickly address the shortfalls we found during our inspection visit.'*

In your evidence you said quality checks were carried out and were robust.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 5a (Schedule E) (2)

5) Failed to ensure that services delivered/provided at the Home were well-led/supervised:

2		Did not ensure that that the Accessible Information Standard 2016 was appropriately met

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2018 inspection. It also took account of your evidence.

The panel noted that the only evidence the NMC relied upon for this charge was that of Witness 2. The NMC did not provide a copy of the document Accessible Information Standard 2016, nor were examples provided as to how it was not appropriately met.

You said that to the best of your ability you ensured that the recommendation in the document was followed at the Home, but you could not recall the detail of how you followed it.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 5a (Schedule E) (3)

5) Failed to ensure that services delivered/provided at the Home were well-led/supervised:

3		Did not ensure that the Home accommodation met the standards of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2004

This charge is found NOT proved.

In reaching this decision, the panel bore in mind its previous decision in respect of the amendment of this charge. As the charge stands the NMC have no evidence to support this charge.

The panel therefore finds this charge not proved.

Charge 5b

5) Failed to ensure that services delivered/provided at the Home were well-led/supervised:

   b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term '*generally*'. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 6a (Schedule F) (1)

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Service User	**Event**
N	Did not adequately investigate allegations brought to you attention by Kent County Council that on, or around 22 October 2019, that Staff Member 2 has been speaking to Service User N in an offensive/threatening/sexual manner

This charge is found NOT proved

In reaching this decision, the panel took into account the evidence that the NMC relied on namely Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal (NOP) dated 6 February 2020. It also took account of Witness 1's evidence and your evidence.

The panel found that Witness 1 was a reliable and credible witness. Witness 1 stated:

> *'Finally we observed a new carer with a resident who was unsettled and required a lot of attention. I don't recall the name of this carer. We found that the carer made inappropriate comments to the resident, spoke to the resident in a condescending matter, and referred to the resident's personal care in a disrespectful manner. For example, the resident required help with his continence.*
>
> *The staff member told the resident that there was nothing wrong with his "bottom" and if the resident kept complaining the staff member [PRIVATE].*

During her oral evidence, Witness 1 confirmed to the panel she could not remember the name of the carer and therefore could not assist the panel with whether or not it was Staff Member 2.

Additionally, the matter was raised in the CQC inspection report exhibited by Witness 2 for the inspection visit in December 2019. Which stated;

> *'• During the first day of the inspection further allegations of abuse were made that had already been raised which had also not been robustly investigated by the registered provider. These concerns related to the inappropriate behaviour of a member of staff towards people.*
> *• We raised this with the registered provider who lacked understanding in how safeguarding matters should be investigated and who did not investigate the allegations robustly.*
> *• Where potential safeguarding concerns were raised the registered provider failed to recognise these and did not follow local safeguarding procedures. One person told us they had raised a specific concern about how a member of staff had spoken to them whilst they were being supported with personal care. The registered provider dismissed their concerns and failed to report them to the local authority safeguarding team or act to safeguard them further. We had to repeatedly ask for them to do so.'*

The panel considered Witness 2's evidence regarding the December 2019 inspection.

He told the panel in oral evidence that he had serious doubts about that inspection at the time and still did. He said:

> *'I have been an inspector -- I have in and around residential care services, nursing services, for 42 years. I've been an inspector for 20 years, prior to me leaving CQC entirely. I have done hundreds -- or I've done thousands of inspections. I have been into hundreds of care homes, and I've never been in an inspection like that one. Because even though (Inaudible) objected to it at the time, there were six staff, wasn't there, doing the inspection. There were*

two inspectors, there was an inspection manager, there was an expert by experience, so there was a specialist professional adviser, and somebody else. There was someone there through county council who was in in (Inaudible) contract. So, there were six people there. For quite long periods during the day, I felt sorry for Ms Persand. People were firing questions at her. I mean I remember one incident where she was sitting in the room and four people were firing questions at her. Asking her to get all sorts of records. I don't know how she managed to get through the day, I certainly wouldn't have. And I argued against that, I felt it was wholly unreasonable to have all those people there, but I was overruled.'

Witness 2 also said, in relation to the 2019 inspection that the second (December 2019) inspection *'was inherently unfair to Mrs Persand.'* He described considering the inspection report of 2019 to be '*wholly unfair*'

The panel also considered the NOP which was exhibited by Witness 2. This document sets out the CQC's reasons for the cancellation of the registration of the Home, Abbey Court Nursing, as a provider.

The NOP stated:

'*On 22 October 2019 your registered manager had been told by Kent County Council that Staff Member 2 had had been heard speaking to* [Service User N] *in an offensive, threatening and sexual manner on that date. You did not take direct action to limit or to supervise the contact Staff Member 2 had with* [Service User N] *even though Kent County Council again drew the matter to your attention in writing on 5 November 2019.'*

Witness 2 stated in his oral evidence;

'My job is to write the notice of proposal because that's part of my job. Usually, information that was given that was generated during the [inaudible] to activity. My job was to write it. I remember this was the NOP one. This was quite unusual this inspector activity from start to finish. It would then lead to

head of inspection, who would then read it and sign it. Only after it had been signed by the head of inspection would it then become something that we would then send the reports. This was quite an unusual at because it was much longer than any other NOP I have ever written or seen. I was told to put everything in it.

Q. Who told you to do that?

A. It was an instruction by Witness 3. I was told to put everything in it and when I raised concerns, serious concerns about the way the inspection report was edited, in particular, me not being allowed to put in positive -- to use those positive examples about Ms Persand they didn't form part of the NOP either. Because I was told that the purpose of the NOP is to get a result for the CQC and the result for CQC was cancelling her registration.

Q. This one was unusual in that regard?

A. It's unusually long, unusually detailed and I was told to put everything in, and to be literal and that's what I did because that's my responsibility. Either I do that, or I choose not to work for the CQC.'

The NOP exhibited by Witness 2 was written by him, however it was signed by another individual who was not present at this hearing and had not provided a witness statement.

You also told the panel that you had never received the NOP from the CQC to cancel the Home's registration as a provider in respect of the regulated activity; accommodation for persons who require nursing or personal care. However, the panel noted that this letter was dated 6 February 2020 and was sent to the Home's registered address.

The panel noted that you had dismissed Staff Member 2 in December 2019, but you did not agree that you were made aware of any incident in October 2019 or November 2019.

The panel determined that the NMC did not make its case that the carer identified was Staff Member 2 and there was no further information that could assist with whether you adequately investigated the concern raised in October 2019.

The panel could not rely upon the evidence contained within the 2019 Inspection Report, nor could it rely on the evidence contained within the NOP in relation to this charge. Witness 2 undermined his own evidence in relation to these documents. The panel has already set out its conclusions on the unreliability of his witness statements. The panel determined, as a result of the conflicting information before it, and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. The charge is found not proved.

Charge 6a (Schedule F) (2)

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

2	N	Did not limit or supervise contact between Staff Member 2 and Service User N, following allegations of abuse being brought to you attention by Kent County Council on, or around 22 October 2019 and/or 5 November 2019

This charge is found NOT proved

In reaching this decision, the panel took into account the evidence that the NMC relied on namely Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal (NOP) dated 6 February 2020. It also took account of Witness 1's evidence and your evidence.

The panel bore in mind its findings at 6a (Schedule F)(1).

The panel found that Witness 1 was a reliable and credible witness. Witness 1 told the panel she could not remember the name of the carer and therefore could not assist the panel with whether or not it was Staff Member 2.

The panel noted that you had dismissed Staff Member 2 in December 2019, but you did not agree that you were made aware of any incident in October 2019 or November 2019.

The panel could not rely upon the evidence contained within the 2019 Inspection Report, nor could it rely on the evidence contained within the NOP in relation to this charge. Witness 2 undermined his own evidence in relation to these documents. The panel has already set out its conclusions on the unreliability of his witness statements. The panel determined, as a result of the conflicting information before it, and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. The charge is found not proved.

Charge 6a (Schedule F) (3 and 4)

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

3	K	Did not adequately investigate allegations of abuse made by Service User K against Staff Member 2
4	K	Did not report allegations of abuse raised by Service User K against Staff Member 2 to (a) the CQC and/or Kent County Council

These charges are found NOT proved

In reaching this decision, the panel took into account the evidence that the NMC relied on namely Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the

Notice of Proposal dated 6 February 2020. It also took into account Witness 3's evidence and your evidence.

Witness 3 during her oral evidence produced a copy of her site visit notes dated 17 December 2019, in relation to the CQC December 2019 inspection. However, these notes did not assist the panel in determining this charge because there was a lack of consistency in the identification of both staff members and service users in respect of these charges. In particular these notes did not refer to Service User K.

The panel could not rely on Witness 2's evidence or NOP for the same reasons as previously set out. In the absence of any other evidence in respect of the charges, the panel determined that the NMC has not discharged its burden of proof.

The panel therefore finds the charges not proved.

Charge 6a (Schedule F) (5)

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

5		Did not promptly notify the Disclosure and Barring Service of Staff Member 2's dismissal

This charge is found NOT proved

In reaching this decision, the panel took into account the evidence that the NMC relied on namely Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the NOP. It also took account of your evidence.

The panel noted that the evidence relating to this charge is contained within the Notice of Proposal. Within the notice of proposal it was stated:

‘C1.5. You failed to promptly notify the Disclosure and Barring Service about the dismissal of Staff Member 2. This inaction increased the risk that other providers of health and social care services would not know about the misconduct of Staff Member 2 when considering them for employment. You failed to act for a period of six days only made the notification when reminded about your duty to do so by the local safeguarding team.’

When questioned by Ms Girven regarding Staff Member 2, you said:

‘I called him in the office after when I was free from the inspectors... Then I informed him to leave before I reported him to the DBS.
Q. And did you report Staff Member 2 to the DBS?
A. Yes.
Q. When did you do that?
A. On the same day, but I can't tell you the exact time. From what I can recollect, I can't remember what time the inspection finished because it was all happening on that day. I'm trying to look after ten residents.’

The panel did not have any information in respect of the Disclosure and Barring Service (DBS) referral or when this was made and recorded.

The panel has borne in mind its conclusion on Witness 2’s evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2’s evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 6a (Schedule F) (6)

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

6		Did not take appropriate precautions to safeguard service users from the risk of abuse by Staff Member 1

This charge is found proved

In reaching this decision, the panel took into account the evidence that the NMC relied on namely Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019. It also took account of Witness 1's evidence and your evidence.

Witness 1 in her statement stated:

> *'There were concerns around the management of risks around staff members. For example, one of the registered nurses named* [Staff Member 1] *had been investigated by the NMC and had a caution on her registration for 30 months from December 2018. However, on review of the employment records there was no risk assessments or support plans in place to manage any potential risks that* [Staff Member 1]'s *fitness to practise could present for residents, or how the Registrant would support this nurse to improve the standards of care provided.'*

Further concerns were raised about Staff Member 1 and Witness 1 said the investigation carried out by you was poor, in that you only spoke to two other members of staff. She stated:

> *'The fact that we didn't feel it had been investigated or substantially risk assessed. That was a risk to us. Then the fact that another allegation had been made about the same person where we've already got risks… we'd expect there to be risk assessments. We'd also expect there to be lots of support in place for that member of staff. For whatever reason, they've been through this experience and come out with this caution. We would expect there to be regular detailed supervision. Regular looks at the risk assessment. Regularly reviewing that risk assessment. Now, when this then allegation came in, we would expect that there to be a thorough risk assessment around*

that. This nurse was on shift on her own as the lead nurse quite a lot. And obviously when you are on your own with vulnerable people, that is a concern to us. We would expect there to be a level of supervision. We just weren't happy with how it was managed at all.'

You said that Staff Member 1 was supervised for three months when you received the call from the NMC. You said there was an investigation but there was no case to answer.

The panel considered the evidence and found that Witness 1 was consistent. The panel did not have sight of any supervision notes or the staff records of Staff Member 1. It was satisfied that Witness 1 provided a first-hand account of her reviewing the files at the time and identifying that there was a risk that was not addressed.

The panel therefore determined that the NMC had discharged its burden of proof. The charge is found proved.

Charge 6a (Schedule F) (7)

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

7		Did not ensure that any and/or all of Staff Members 1, 2, 3 and 4 had received training in how to adequately respond to abuse

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, and the NOP. It also took account of your evidence.

The panel noted that the evidence relied upon for this charge was the Notice of Proposal, within this document there were appendices of training undertaken in house by staff. The documentation did not show which staff members had undertaken the training and therefore did not assist with whether staff members 1,2, 3 and 4 had received training in how to adequately respond to abuse.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 6b

6) Failed to ensure that the Home safeguarded service users from abuse/improper treatment and/or complied with Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

   b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 7a (Schedule G) (1)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

1		Did not ensure that any and/or all of Staff Members 1, 2, 3 and 4 knew the correct fire procedures and/or how to follow the Personal Emergency Evacuation Plan (‘PEEP’) for one, or more, service users

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2’s evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel noted that CQC inspection report for the December 2019 stated:

> *‘There were serious shortfalls in the arrangements to assist people with reduced mobility to move to a place of safety in the event of fire. Each person had a Personal Emergency Evacuation Plan (PEEP) which described the action staff should take in the event of fire. The registered manager said it was "Essential" for staff to follow the guidance in the PEEPs. However, staff*

did not know about the PEEPs and information in three PEEPs we reviewed was incomplete and/or incorrect. This was unsafe.'

You said that the staff members were aware of the PEEPs. When questioned,

'Q. You didn't check with them, did you, that they were aware of the contents of those documents?

A. Yes, we do because we do fire training and we do fire drill.'

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (2,3 and 4)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

2	D	Did not ensure that the information in the service users PEEP was complete/accurate
3	J	Did not ensure that the information in the service users PEEP was complete/accurate
4	K	Did not ensure that the information in the service users PEEP was complete/accurate

These charges are found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the NOP. It also took account of your evidence.

The panel had sight of the PEEPs for each service user which appeared to be completed. No further evidence was provided to demonstrate why each PEEP was either incomplete or inaccurate.

You said,

> *'… when there's a fire, the PEEP is to grab the paperwork, You don't want lengthy paperwork, it has to be very quick and easy. It's not just for the staff, it's for the fire brigade as well which doesn't know the client, so it has to be very short.'*

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. These charges are found not proved.

Charge 7a (Schedule G) (5)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

5		Did not ensure that one, or more, members of staff attended a fire drill at least every 3 months

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel reviewed the CQC inspection report which stated: *'Not all staff attended fire drills to ensure they knew the correct procedures in the event of a fire. Staff lacked understanding about which fire extinguishers should be used should one occur*.'

The panel saw evidence of the fire drill record sheets that identified fire drills on 24 January 2019, 6 May 2019 and 17 November 2019. The panel had no further information to support the charge, in particular whether there was a requirement to attend a fire drill every three months.

You told the panel that fire drills were conducted regularly in accordance with the Home's policy. All staff members were involved. A record was kept of each fire drill. You stated that you no longer have access to the Home's documentation.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (6)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

6		Did not endure that ongoing checks of the Home's emergency lights were undertaken as appropriate

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

When questioned about the emergency lights, you said,

> "*They are checked on a weekly basis, that is internally. Externally, we have a contractor that comes in and does the checks every six months, but all fire alarms are tested on a weekly basis by the handyman".*

The panel also considered that the evidence in respect of this charge was contained in the CQC inspection report for the December 2019 inspection visit and the Notice of Proposal, these documents were provided by Witness 2.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (7 and 8)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

7	L	Did not ensure that Service User L and/or other services users with reduced mobility were assisted to transfer safely and/or with the assistance of at least 2 members of staff
8	L	Did not ensure that an appropriate/full-body sling was used for Service User L when transferring to the toilet

The charges are found proved in relation to Service User L

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of Witness 3's evidence and your evidence.

The panel had sight of Service User L's care plan exhibited with the NOP, which identified their mobility needs.

It also had sight of a Summary of KCC funded Occupational Therapy (OT) Intervention for the Home, completed on 5 July 2019 and updated on 20 January 2020, relating to OT involvement between 24 January 2019 to 28 November 2019. The content of this document was not linked specifically to individual service users. The panel was therefore unable to rely upon this as the occupational therapist was not called as a witness in this hearing.

During the course of Witness 3's evidence she produced Exhibit 5, her site visit notes dated 17 December 2019 as part of the CQC December 2019 inspection visit. She confirmed that she was the author of the notes and that they were written at the time of the visit to the Home. The notes were dated and time stamped. The notes stated:

'Service User L

I observed SM2 making SU:L comfortable in her armchair following a hoist transfer. I didn't witness the transfer but SM2 confirmed he did this alone but that it is easier with two staff.

I asked SM2 how SU:L is moved. He said a hoist with a toiletting [sic] *sling because this is what she is used to even though she no longer uses a toilet. SM2 said that SU:L uses a full sling hoist when upstairs but that this cannot be brought downstairs. Care plan dated 28.11.2019 - states cannot weight bear. Need to be transferred with a full body hoist with the help of two staff. Care plan states high risk of falls. But risk assessment for falls says low risk.*

Risk assessment states needs full body hoist with medium sling for all transfers including from floor. Also states uses slide sheets and two staff to reposition in bed. Staff Member 3 said SU:L uses slide sheets and they are in her bedroom.

RGN Staff Member 1 said SU:L uses hoist and toileting [sic] *sling with two staff required. SM1 said SU:L uses a commode over the toilet after lunch but is doubly incontinent. There was no specific care plan about toilet needs.*

There were conflicting views between staff about how to move SU:L safely.'

During your evidence you said that your staff were using the hoist in the right way. You also said that each client had their own individual sling with their name written on it, to prevent infection.

The panel found that Witness 3 was credible and reliable in her evidence and that her notes were made contemporaneously. The panel therefore preferred Witness 3's evidence to yours. These charges are found proved in relation to Service User L.

Charge 7a (Schedule G) (9)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

9	D	Did not ensure that an appropriate/'in situ' sling was used for Service User D

The charge is found proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of Witness 3's evidence and your evidence.

During the course of Witness 3's evidence she produced Exhibit 5, her site visit notes dated 17 December 2019 as part of the CQC December 2019 inspection visit. She confirmed that she was the author of the notes and that they were written at the time of the visit to the Home. The notes were dated and time stamped, it stated:

> *'Service User D… OT plan dated 10.10.19 for use of hoist. In-situ sling to be used to replace use of toiletting* [sic] *sling.*
> *This was not in use with SU:D. Asked SM3 what sling* [*SU:D*] *uses. He went upstairs and got full body sling. I asked SM3 and SM1 why an in-situ sling was not used as per OT recommendation. They both struggled to understand the question. Eventually they said it is not used. SM1 said the sling would not be suitable to be left in-situ.'*

It also had sight of a Summary of KCC funded Occupational Therapy (OT) Intervention for the Home, completed on 5 July 2019 and updated on 20 January 2020, relating to OT involvement between 24 January 2019 to 28 November 2019. The content of this document was not linked specifically to individual service users but was evidence of OT involvement at the time Witness 3 makes a note of an OT plan for service User D dated 10 October 2019.

During your evidence you said that your staff were using the hoist in the right way. You also said that each client had their own individual sling with their name written on it, to prevent infection.

The panel found that Witness 3 was reliable in her evidence and that her notes were made contemporaneously. The panel therefore preferred Witness 3's evidence to yours. The charge is found proved.

Charge 7a (Schedule G) (10)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

10	K	Did not ensure that staff encouraged Service User K to change position in bed and/or that consistent arrangements were undertaken by staff to do so

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and Service User K's care plan as an appendix in the NOP. It also took account of your evidence.

The panel noted that Service User K's care plan indicated their mobility needs. The care plan showed that Service User K was bed bound and that they would need assistance when being repositioned in bed by two carers.

The panel also considered that the evidence in respect of this charge was contained in the CQC inspection report for the December 2019 inspection visit and the NOP which contained Service User K's care plan, these documents were provided by Witness 2.

You denied the allegation and did not accept that Service User K *'required regular moving'.* You also stated that staff would always make sure *'he is on the side, whichever side he's supposed to be'.*

The panel found that there was conflicting information with regards to the wording of the care plan and the charge. Service User K's care plan did not mention that staff needed to "encourage" them when being repositioned.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence.

The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (11)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

11	J	Did not ensure that staff encouraged Service User J to change position in bed and/or that consistent arrangements were undertaken by staff to do so

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal and Service User J's care plan as an appendix. It also took account of your evidence.

The panel considered the evidence before it and found that Service User J's care plan did not assist in supporting the charge, namely whether you ensured that staff *"encouraged Service User J to change position in bed*".

The panel also noted that the NMC relied upon Witness 2's evidence in respect of the CQC inspection report for the December 2019 inspection visit and the NOP.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (12)

8) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

12	K	Did not ensure that appropriate instructions/processes were in place to provide appropriate/safe catheter care for Service User K

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal, Service User K's care plan and analysis of fluid chart as appendices. It also took account of your evidence.

Service User K's analysis of fluid chart mentioned what carers needed to do with the catheter. *'The catheter is changed if there are blockages and urine is not flowing freely in the bag'.*

When questioned about Service User K's catheter care you said,

> *'A. It would be a separate document which would be in his bedroom because the catheter care would be done on a regular basis …, there will be documentation about the input and output of the urine and what time it was emptied. So, the catheter care would be a separate document which would be in the client's bedroom.'*

The panel had not been provided with any further catheter care documentation.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (13)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

13	K	Did not ensure that Service User K was consistently supported to eat and drink safely

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal, Service User K's care plan, weekly food record chart and analysis of fluid chart as appendices. It also took account of your evidence.

The panel considered all the evidence before it and noted that the evidence relied upon by the NMC actually demonstrated that Service User K *was* eating and drinking regularly. The weekly food chart and the analysis of fluid chart recorded Service User K's input and output.

The panel determined that the NMC had not discharged its burden of proof. It therefore finds this charge not proved.

Charge 7a (Schedule G) (14)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

14	J	Did not ensure that Service User J was consistently assisted to sit in an upright position when eating and drinking to reduce the risk of choking

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal and Service User J's care plan as an appendix. It also took account of your evidence.

The panel noted that Service User J's care plan identified how they were to be fed and given their fluids. It stated that Service User J is to be sat upright in bed and alert at any time when eating and drinking to minimise the risk of choking.

The panel noted that the only evidence the NMC relied upon came from Witness 2. The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined

there was no further evidence to corroborate the charge. The NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (15)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

15		Did not ensure that staff were provided with written/appropriate guidance about providing emergency first aid if a service user choked

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated the following:

> *'C2.28. We found that nurses and care staff had not been provided with written guidance about providing emergency first aid if a service user choked on food or drink. Staff Members 1, 2, 3 and 4 did not know what action to take. In response to our question Staff Member 1's reply extended only to patting themselves on the back to show how they would try to dislodge the obstruction. Staff Member 4 said, "I ask nurse what to do and get food out of neck.'*

You told the panel that first aid information was available *"everywhere, on the nursing side, there was in the kitchen, there was different places on the premises."* You also said that staff members had undertaken "mini- training" to assist when someone is choking.

The panel has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (16)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

16	L	Did not ensure that one, or more, staff were aware/followed Service User L's care plan in relation to their cheese allergy

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, Notice of Proposal and Service User L's care plan as an appendix. It also took account of your evidence.

The Notice of Proposal stated,

> *'C2.29. The care plan of Service User* [L] *who did not have mental capacity said they were allergic to cheese. Staff Members 1, 2, 3, 4 and 5 did not know this information. There was no guidance about what response should be offered if Service User* [L] *asked for a dish containing cheese. Staff Member 4 said, "Of course they have cheese if they want. They ask me, and I will get for them, no problem kitchen has lots of food."*

When questioned about Service User L's cheese allergy, you said you were aware. You said there was a system in place to make staff aware. In each client's room

there would be an A4 paper which would clearly in bold writing say “Allergies”. You said the allergies could be anything. You also said that if client were not in their room, kitchen staff have knowledge of all the Home’s clients’ allergies to ensure no cross contamination.

The panel has borne in mind its conclusion on Witness 2’s evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2’s evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (17)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

17		Did not ensure that medicines were managed safely

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2’s evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and Notice of Proposal. It also took account of your evidence.

The panel noted that the only evidence presented for this charge was provided by Witness 2. It has borne in mind its conclusion on Witness 2’s evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2’s evidence. He undermined his own evidence. The panel determined that there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (18)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

M	Did not ensure that the administration of Hydroxocobalamin to Service User M between 26 November 2019 and 22 December 2019 was countersigned

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and Notice of Proposal. It also took account of your evidence.

The panel was aware that they had not been provided with the Home's medication policy or Service User M's medical records. The evidence relied upon by the NMC was that of Witness 2 and the exhibited documents.

You said in your oral evidence that only controlled drugs needed to be countersigned and this medication for Service User M did not need to be countersigned.

The panel noted that the only evidence presented for this charge was provided by Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (19)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

19	M	Did not ensure that Service User M received the correct dose of Oxypro (5mg) and/or the correct dose was accurately recorded on: a) 9 December 2019; b) 14 December 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and Notice of Proposal. It also took account of your evidence.

The panel considered the evidence before it and noted that it had not been provided with Service User M's drug administration chart. The only evidence presented regarding this charge was provided by Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined that there being no further evidence to corroborate the charge, the NMC has failed to discharge its burden of proof. This charge is found not proved.

Charge 7a (Schedule G) (20)

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

20	J	Did not ensure accident forms/reports were accurately completed in respect of Service User J in relation to incidents on: a) 16 November 2019; b) 19 November 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, Notice of Proposal and Service User J's accident reports as an appendix. It also took account of your evidence.

The panel had been provided with Service User J's accident reports relating to this charge, however there was no other evidence to indicate that the forms were inaccurately completed.

You said that the form was completed and that Service User J could not hold the pen and was unable to sign the accident report. You also told the panel you identified that Service User J had two accidents in the space of three days and wrote down a proposed course of action. You said that Service User J had mental capacity and refused to have a nursing bed, they preferred a normal bed. You also mentioned that a crash mattress was placed near to their bed as, Service User J was prone to falling.

The panel identified that the evidence relied upon was from Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 7b

7) Failed to ensure that the Home provided safe care and treatment and/or complied with regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 8a (Schedule H) (1)

8) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	Event
1		Did not consistently ensure that a sufficient number of staff members were working on shifts to meet the needs of service users

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel had sight of the staffing allocation table. This provided the number of staff required for each shift and the total care hours. There was also staffing guidance attached. However, this documentation did not assist with this charge, and whether there were sufficient staff on duty to meet the needs of the service users.

You said that there were sufficient staffing levels.

The panel determined that the evidence relied upon was provided by Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 8a (Schedule H) (2)

8) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

N & A	Did not ensure that staff were available on 19 December 2019 to timeously assist: a) Service User N; b) Service User A

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection. It also took account of your evidence

The panel found the charge to be unclear in what exactly was meant by 'timeously' and what evidence the NMC were relying on to support this charge. It was directed to the CQC inspection report where it was mentioned inspectors saw that it took 10 minutes for service users to be attended to.

You said you were unable to remember how long it took for carers to respond to service users. However, you said,

> *'I'm going to answer you again, the same answer is the call bell will be called. Any member of staff, it doesn't have to be carer, will come because this is called an emergency call button. So, whoever comes, because they are supposed to come -- when the call alarm goes, any member of staff will come. It could be the kitchen staff, it could be anyone, but somebody should come. So as soon as the staff come, if there is an emergency, someone has to deal with it. If somebody needs the toilet, you know, normally, there is a routine in the home.'*

The panel determined that the evidence relied upon was provided by Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate

the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 8a (Schedule H) (3)

8) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

3		Did not ensure that one, or more, staff members were adequately supervised and/or such supervision was adequately recorded;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal and staff supervision records as an appendix. It also took account of your evidence.

The Notice of Proposal identified that the registered manager regularly met with staff members in a supervision session. This was to discuss the member of staff's work and to help them address any shortfall in their performance. It was stated that this was *'poorly organised and delivered'.*

Witness 1 in her witness statement provides some very limited information about supervision notes being generic and not being detailed.

However, the panel having considered the evidence before it, and having had sight of the supervision records for Staff Member 1 and a Personal Development Plan (PDP). The panel determined that overall, it supports your account that you met staff members on a regular basis and that you carried out the supervision meetings.

The panel determined that the evidence relied upon by the NMC was provided by Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined as a result of the conflicting information that the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 8a (Schedule H) (4)

8) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

4		Did not ensure that one, or more, staff members, including Staff Members 1, 2 3 and 4 had all the knowledge and skills need to consistently provide safe care/care in line with national guidance

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal and record of staff training courses as an appendix. It also took account of your evidence.

The panel was provided with a list of completed training courses, but it was not provided with staff members' records. The staff training record does not assist with the charge as it did not specify which staff members had done the training.

Witness 2 in his oral evidence acknowledged that training had taken place.

You said that all staff members were sufficiently trained.

Taking everything into consideration, the panel determined that the evidence relied upon by the NMC was provided by Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. Taking everything into consideration the panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 8a (Schedule H) (5)

8) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

D	Did not ensure that staff were given guidance in care plans and have the competencies needed to consistently support Service User D's needs arising from dementia

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel could not be satisfied that there was documentary evidence of Service User D's care plan. The only evidence relied upon by the NMC was from Witness 2.

During your oral evidence you were asked the following:

> '*Q. If a service user has dementia and is showing signs of distress, for example, Witness 2 recorded that he witnessed them becoming anxious, would you expect your staff to respond to that distress in the same way as each other?*

A. No, because we're all different and it could be -- with dementia, you can't really know what is going on in people's heads, it could be different things. It could be they want to be left -- there's too much noise around them so you don't know what is going into this person's head. There's too much noise, there's too many people. It could be they want to go to the toilet. The list goes on.'

Taking everything into consideration, the panel determined that the evidence relied upon by the NMC was provided by Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. The panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 8b

8) Failed to ensure that the Home provided appropriate staffing and/or complied with regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of

and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 9a (Schedule I) (1(a) and (b))

9) Failed to ensure that the Home employed safe and proper persons and/or complied with regulations 19(1), 19(2) and 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

	Service User	**Event**
1		Did not ensure that a full and continuous employment history was obtained as part of the pre-employment checks for: a) Staff Member 2; b) Staff Member 3

These charges are found NOT proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel noted that this charge arises from the CQC inspection report where it identified the following:

‘• Pre-employment checks for two members of care staff did not have a full and continuous employment history. This shortfall had reduced the registered provider's ability to identify the assurances needed about the applicants' previous good conduct.

• These shortfalls in the recruitment and selection of care staff had increased the risk people would not always receive care from trustworthy members of staff.’

The panel was not provided with the employment files for Staff members 2 and 3.

You denied the allegation and said that any gaps in employment were noted at interview, and you recorded the information on either their application form or their CVs. You said that you would ask them the question regarding any gaps in employment.

Taking everything into consideration, the panel determined that the evidence relied upon by the NMC was provided by Witness 2. It has borne in mind its conclusion on Witness 2’s evidence as set out above. The panel could not place much weight on Witness 2’s evidence. He undermined his own evidence. The panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 9a (Schedule I) (2)

9) Failed to ensure that the Home employed safe and proper persons and/or complied with regulations 19(1), 19(2) and 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

2		Did not fully investigate the suitability of Staff Member 6, who had received two police cautions for violent conduct, to be employed at the Home

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 1's evidence, Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel noted that the Notice of Proposal provides the only information regarding two police cautions. It has already identified that it cannot place much weight on Witness 2's evidence as he has undermined his evidence.

The panel noted that Witness 1 referred to a staff member 6 (the activities coordinator) having convictions (as opposed to cautions) on their DBS and there was no risk assessment around how possible risks would have been managed. Witness 1 said she was not aware of the staff member's full name.

When questioned you denied having a staff member or activities coordinator with the initials [Staff Member 6]. You then provided information in respect of your secretary, and you confirmed she had two police cautions. You stated that a risk assessment had been carried out.

The panel found that there was conflicting evidence in relation to the identity of Staff member 6 and whether they had received cautions or convictions. The panel also noted that it was not provided with any employment files for review.

Taking everything into consideration, the panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 9b

9) Failed to ensure that the Home employed safe and proper persons and/or complied with regulations 19(1), 19(2) and 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 10a (Schedule J) (1)

10) Failed to ensure that the Home was meeting the nutrition and hydration needs of service users and/or complied with regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	Event
1	J	Did not ensure that accurate records were kept for meals taken by Service User J on one, or more, occasion between 16 December 2019 and 22 December 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal, Service User J's nutritional assessment chart, weekly food record chart and daily progress notes as appendices. It also took account of your evidence.

The panel noted that the evidence for this charge came from Witness 2 in the Notice of Proposal, which stated:

> *'C5.2. Your registered manager told us it was necessary to monitor the food intake of* [Service User J, Service User K and Service User L]. *We examined the records of the food these service users had consumed between 16 December 2019 and 22 December 2019. There were 10 meals for which an accurate record had not been created.'*

The panel noted that there was a requirement for Service User J's food intake to be recorded on their food chart on a daily basis. The panel had sight of Service User J's weekly food chart which was dated from 16 – 22 December 2019. The food chart was completed in full and there was nothing before the panel to suggest that it was not accurate. The food chart also corresponded with some comments in Service User J's daily progress notes, which stated what they had eaten on the day.

You accepted that Service User J's food intake needed to be monitored.

The panel concluded that there was no dispute that Service User J's daily food intake needed to be recorded as it was stated in Service User J's nutritional assessment form. The panel considered that the only evidence that supports the charge in respect of the accuracy of this food chart came from Witness 2, whose evidence was unreliable.

Taking everything into consideration, the panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 10a (Schedule J) (2)

10) Failed to ensure that the Home was meeting the nutrition and hydration needs of service users and/or complied with regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

2	K	Did not ensure that accurate records were kept for meals taken by Service User K on one, or more, occasion between 16 December 2019 and 22 December 2019

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal, Service User K's weekly food record charts and evaluation form as appendices. It also took account of your evidence.

The panel noted that the evidence for this charge came from Witness 2 in the Notice of Proposal, which stated:

> *'C5.2. Your registered manager told us it was necessary to monitor the food intake of* [Service User J, Service User K and Service User L]. *We examined*

the records of the food these service users had consumed between 16 December 2019 and 22 December 2019. There were 10 meals for which an accurate record had not been created.'

The panel had sight of Service User K's completed food chart which was dated from 16 – 22 December 2019. It also noted that there were two further copies of Service User K's food chart for these dates, that were half completed but it found that the information corresponded with the completed food chart it had seen. The panel also had sight of Service User K's evaluation form which indicated what food they had also eaten on specific dates. There was nothing before the panel to suggest this was not an accurately completed food intake chart for Service User K.

You told the panel there was no requirement for Service User K to have a daily record of their food intake. You confirmed *"there was an accurate record kept of what* [they were] *eating*".

The panel considered that the only evidence that supports the charge in respect of the accuracy of this food chart came from Witness 2, whose evidence was unreliable.

Taking everything into consideration, the panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 10a (Schedule J) (3)

10) Failed to ensure that the Home was meeting the nutrition and hydration needs of service users and/or complied with regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

3	L	Did not ensure that accurate records were kept for meals taken by Service User L on one, or more, occasion between 16 December 2019 and 22 December 2019

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal, Service User L's weekly food record chart, and nutritional assessment form as appendices. It also took account of your evidence.

The panel noted that the evidence for this charge came from Witness 2 in the Notice of Proposal, which stated:

> *'C5.2. Your registered manager told us it was necessary to monitor the food intake of* [Service User J, Service User K and Service User L]. *We examined the records of the food these service users had consumed between 16 December 2019 and 22 December 2019. There were 10 meals for which an accurate record had not been created.'*

The panel had sight of Service User L's completed food chart which was dated from 16 – 22 December 2019. There was nothing before the panel to suggest this was not an accurately completed food intake chart for Service User L. The panel also had sight of Service User L's nutritional assessment form which did not indicate that their food intake had to be recorded daily.

You told the panel there was no requirement for Service User L to have a daily record of their food intake. You said there was a record kept and it would be in the *"client's room, there was sheet of what they had for breakfast, what they had for lunch and what they had for their tea."*

The panel considered that the only evidence that supports the charge in respect of the accuracy of this food chart came from Witness 2, whose evidence was unreliable.

Taking everything into consideration, the panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 10a (Schedule J (4) and (5))

10) Failed to ensure that the Home was meeting the nutrition and hydration needs of service users and/or complied with regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

4	F	Did not ensure that that one, or more, staff members knew about/recorded the target amount of fluid for Service User F
5	O	Did not ensure that that one, or more, staff members knew about/recorded the target amount of fluid for Service User O

These charges are found NOT proved

In reaching this decision, the panel took into account, Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel noted that the evidence for these charges came from Witness 2 in the Notice of Proposal, which stated:

'C5.3. Your registered manager told us Service User F and Service User [O] *were at risk of not drinking enough and becoming dehydrated. Your registered manager also told us each of the service users needed to drink at least two litres of fluid each day to maintain their health. However, there was no system for nurses and care staff to monitor how much fluid Service User F and Service User* [O] *had drunk. In addition, Staff Members 1, 2, 3, 4 and 5 did not know about the target amount your registered manager had set.*

The panel had not been provided with Service User F's fluid intake chart or catheter chart which monitored their fluid output or Service User O's fluid intake records.

During your evidence you did not accept that either service user needed to be given specific amounts of water every day or that it should be recorded. You also maintained that Service Users F and O only needed to be encouraged to remain hydrated.

Taking everything into consideration, the panel determined that the only evidence relied upon by the NMC was provided by Witness 2. It has borne in mind its conclusion on Witness 2's evidence as set out above. The panel could not place much weight on Witness 2's evidence. He undermined his own evidence. The panel determined that the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 10b

10) Failed to ensure that the Home was meeting the nutrition and hydration needs of service users and/or complied with regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 11a (Schedule K (1))

11) Failed to ensure that the Home was adequately complying with the consent to care requirements of service users and/or complied with regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

	Service User	**Event**
1	N	Did not ensure that suitable provision had been made to obtain consent in line with the Mental Capacity Act 2005

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel noted that in respect of this charge, the only evidence offered was the Notice of Proposal dated 6 February 2020. It has already identified that it cannot place much weight on Witness 2's evidence as he has undermined his evidence. The Notice of Proposal at paragraph C6.1 states:

> *' C6.1. We found that suitable provision had not been made to obtain consent and provide lawful care in line with the Mental Capacity Act 2005. Service users were not consistently supported to make everyday decisions for themselves. An example was Service User* [N] *on the second day of the inspection visit who wanted to remain seated at the dining table to rest after having their meal. During a period of 15 minutes Staff Members 1, 3 and 4 approached Service User* [N] *and with increasing firmness suggested they move to sit in the lounge. In the end Staff Member 4 lifted Service User* [N[*'s arm motioning for them to get up from their chair and the service user reluctantly complied. They sighed and said, "Oh well if I have to I'll move."'*

The panel noted that, in relation to the alleged incident mentioned by the inspector, you were not present. Three separate members of staff were involved. The panel found that it was unclear how the example presented by the NMC related to the charge.

You confirmed in your evidence that you were not there when this incident took place. You explained that each client is assessed on an individual basis. You said,

> *'we don't force anyone to do things. You go back and encourage them, that's my understanding'.*

Taking everything into consideration, the panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate

the charge, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 11a (Schedule K (2))

11) Failed to ensure that the Home was adequately complying with the consent to care requirements of service users and/or complied with regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

2	D	Did not ensure that an assessment was completed to see if Service User D had the mental capacity to consent to sharing a bedroom

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 1's evidence, Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal and Service User D's care plan evaluation sheet as an appendix. It also took account of Witness 3's evidence and your evidence.

The panel noted that the Notice of Proposal provides information regarding Service User D. It has already identified that it cannot place much weight on Witness 2's evidence as he has undermined his evidence.

The panel noted in the Notice of Proposal at paragraph C6.2 it stated,

> *'C6.2. Your registered manager told us they considered each service user's mental capacity to make decisions about their care. They said when necessary they consulted with relatives and healthcare professionals if a significant decision needed to be made about the care provided for a service user. However, in practice decisions were not being made in the right way. An assessment had not been completed to see if Service User* [D] *who occupied a shared bedroom had the mental capacity to consent to the arrangement…'*

During the course of Witness 3's evidence she produced Exhibit 5, her site visit notes dated 17 December 2019 as part of the CQC December 2019 inspection visit. She confirmed that she was the author of the notes and that they were written at the time of the visit to the Home. The notes were dated and time stamped, it stated:

> *'Service User D- shares a bedroom but all records show she cannot consent to this. SM1 said SU:D cannot consent to this. relative consulted but no MCA completed.*
> *MCA assessments completed for bedrails, receiving personal care. Mobility.'*

The panel found Witness 3's notes in relation to Service User D's mental capacity assessment somewhat confusing and contradictory.

The panel noted that you did not dispute that Service User D shared a room with another user, however you could not recall whether Service User D had capacity in December 2019.

You said you recalled that it was the choice of Service User D and their family for them to share a room.

When giving evidence, you were asked the following question:

> *'Had there been any assessment to check whether Service User D had the capacity to consent to that arrangement?*
>
> *A. Yes, when they first came to us, the family and friends and the client themselves we go around and visit the home and chose which room they would want to have and some of the residents would want to share a room because they feel safe, they have someone with them. In that case, I remember these two ladies had a shared room because it was a choice.*
>
> *Q. Did you do a formal assessment of Service User D's capacity to consent to that arrangement?*

A. When we review monthly, we would ask that question.

Q. So there was no formal assessment of her capacity?

A. Reviewing her care is a formal assessment about her capacity'

The panel also considered there was evidence of four care plan reviews between October 2019 and December 2019. The review on 18 October 2019, showed that a family member was in attendance when the review was conducted and indicated they were happy with the care their relative had received.

The panel also considered that Witness 1 in her witness statement referenced rooms being shared at the Home, but did not mention which service users were sharing the room. This could not assist the panel in its decision.

Taking everything into consideration, the panel determined, as a result of the conflicting information before it the NMC have failed to discharge its burden of proof.

This charge is found not proved.

Charge 11a (Schedule K (3))

11) Failed to ensure that the Home was adequately complying with the consent to care requirements of service users and/or complied with regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

3	O	Did not ensure that relatives and/or healthcare professionals were consulted in relation to Resident O who was regularly encouraged to have bed rest in the afternoon

This charge is found NOT proved

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the

December 2019 inspection and Service User O's care plan evaluation sheet as an appendix. It also took account of your evidence.

The panel noted in the CQC inspection report it was stated,

> *'People and their relatives were not being consulted with the reviews of their care. People and relatives told us they were not involved with the reviews and their records confirmed this.'*

The panel considered Service User O's care plan evaluation sheet, it had particular regard to the entry on 3 October 2019. A family member wrote that they had read the care plan to Service User O and made sure they understood as *'far as is possible'.* The family member wrote,

> *'My impression is that it gives a detailed, fair and accurate assessment of* [Service User O's] *present condition and* [their] *care needs, which I am satisfied are being met.'*

The panel also noted that the care plan was reviewed in November 2019 and December 2019.

In your evidence you stated that Service User O had capacity and that she wanted to be on bed rest, you said this was also discussed with family and friends.

Taking everything into consideration, the panel determined that there was evidence to support your account and therefore, the NMC have failed to discharge its burden of proof. This charge is found not proved.

Charge 11a (Schedule K (4) and (5))

11) Failed to ensure that the Home was adequately complying with the consent to care requirements of service users and/or complied with regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

4	L	Did not ensure a condition relating to a review as to whether Service User L should be resuscitated was completed/recorded
5		Did not know whether conditions were imposed on one, or more, authorisations under the Mental Capacity Act 2005 and/or ensure that Staff Members 1, 2, 3, 4 and/or 5 were aware of such conditions

The charges are found NOT proved

In reaching this decision, the panel took into account Witness 1's evidence, Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal and Service User L's care plan as an appendix. It also took account of your evidence.

The panel noted that the information relating to the charges came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he has undermined his own evidence.

It was stated in paragraphs C6.3 and C6.4,

> *'C6.3. Authorisations had been obtained when a service user lacked mental capacity and needed to be deprived of their liberty to receive the care and treatment they needed. However, there were shortfalls in the arrangements used to ensure any conditions placed on authorisations were implemented. Conditions are usually imposed by the body issuing an authorisation if special provision needs to be made to minimise the restrictions a service user experiences. Your registered manager did not know if any conditions had been imposed on each authorisation. Staff Members 1, 2, 3, 4 and 5 did not*

know conditions could be attached to authorisations. This had contributed to shortfalls in the arrangements made to implement conditions.

C6.4. An example of this was a condition saying a historic decision needed to be reviewed about Service User [L] *not being resuscitated in an emergency. The review had not been completed and no arrangements were planned to address the shortfall. We raised the matter with your registered manager who assured us the shortfall would quickly be addressed.'*

The panel noted that in Service User L's care plan it was written that a Deprivation of Liberty Safeguards (DoLS) was in place, however it was not provided with the actual DoLS form or information on when it needed to be reviewed and at what intervals.

Witness 1 in her witness statement, stated that,

'*From our July 2019 action plan the only thing that had been completed was that a Deprivation of Liberty ('DoLs') tracker had been put in place, and the remaining improvements still required action.'*

During the course of her evidence, Witness 1 explained further about DoLS and what information was expected to be recorded.

Further, Witness 1 in her witness statement following a visit by Kent County Council in October 2019 stated that, *'Mental Capacity Assessments were on file and these were decision specific and completed correctly'.*

The panel were not provided with information about Service User L's mental capacity regarding the DoLs and what conditions were in place. The panel did not have any information on whether or not staff members may have been made aware of the conditions in place.

In your evidence, you answered in the affirmative that you made sure you were aware of conditions that were on the DoLs documents. You also said that staff

members would be aware of the conditions imposed on the authorisations and that the documents were contained in a folder.

The panel bore in mind that it did not have sight of the DoLs documents for service users. It had no information from the NMC in respect of the conditions and what it was that staff members needed to be aware of in this respect. Taking everything into consideration, the panel determined, as a result of the conflicting information before it and there being no further evidence to corroborate the charges, the NMC have failed to discharge its burden of proof. These charges are found not proved.

Charge 11b

11) Failed to ensure that the Home was adequately complying with the consent to care requirements of service users and/or complied with regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

b) Generally;

This charge is found NOT proved

When considering this charge, the NMC were unable to adequately explain what was meant by the term '*generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence

matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 12a (Schedule L (1))

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule L;

	Service User	**Event**
1	O	Did not ensure that Staff Member 3 communicated/engaged with Service User O appropriately when assisting them with eating on 19 December 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel had regard to the Notice of Proposal which stated:

> *"C7.2. During lunch on the second day of the inspection we saw Staff Member 3 assisting Service User [O] to eat their pudding. Staff Member 3 who was not fluent in spoken English alternated between using English and words we could not recognise. As a result, Service User [O] misunderstood what was being said to them. They tried to hold the spoon being held by the Staff*

Member 3 rather than opening their mouth as had been requested. Staff Member 3 then switched from using unrecognisable words and in a loud voice said, "No, no you open mouth now. You not take spoon, I hold spoon. You eat this now, I help you." Service User [O] moved their head from side to side indicating they did not want to eat any more of their pudding. However, Staff Member 3 did not realise this and repeatedly followed the Service User [O]'s mouth with the spoon. Eventually, we suggested to Staff Member 3 that Service User [O] *did not want to eat any more."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel took into account your evidence. During your evidence you informed the panel that the Home had a communication protocol and that members of staff would have been trained on this protocol during their induction. You suggested that people would not always remember everything in the policy but that they could always refer to the policy documents to ensure a good level of communication was maintained.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, this charge is found not proved.

Charge 12a (Schedule L (2))

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule L;

2	A	Did not ensure that Staff Member 4 promoted the privacy/ dignity of Service User A when using the toilet on 19 December 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel had regard to the Notice of Proposal which stated:

> *"C7.4. Service users' independence was not fully promoted. An example of this occurred on the second day of the inspection visit when we were in the corridor near to a communal toilet as Service User [A] was helped by Staff Member 4 to enter the room. Before the door was closed we heard the Staff Member 4 say, "No I undo that for you as you slow with buttons and I faster so we get done. No leave them I do them for you and we get you back to seat in lounge."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel took into account your evidence during which you informed the panel that from your recollection none of the service users were able to use the toilet independently or undress themselves. You stated that they all required help to do this. In relation to this specific incident as charged, you stated you had not been made aware of this having occurred.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2

to support this charge, the NMC have failed to discharge its burden of proof. Therefore, this charge is found not proved.

Charge 12a (Schedule L (3))

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule L;

3	L	Did not ensure that Staff Member 4 promoted the privacy/ dignity of Service User L when using the toilet on 19 December 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel had regard to the Notice of Proposal which stated:

> *"C7.6. On the second day of the inspection visit we saw Service User [L] as they were supported by Staff Member 4 to use a communal toilet that did not have a lock on the door. There was a sign on the door to indicate if the room was occupied. After Service User [L] was helped into the room Staff Member 4 did not change the sign to show the facility was in use. Also, they did not wait outside in case another service user wanted to go in. We noticed another service user was walking towards the toilet and was about to go in. We politely asked them to wait to prevent embarrassment for both service users."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel

previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel took into account your evidence during which you stated that there were signs on the door which read "occupied" or "unoccupied" and that these could be used in the event that a Service User was unable to lock the toilet door. During your evidence you informed the panel that your office was located between the two toilets, and you were not made aware of this specific incident.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof. Therefore, this charge is found not proved.

Charge 12a (Schedule L (4))

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule L;

4	O	Did not ensure that Staff Member 4 supported Service User O in actively making a decision as to whether to go to their bedroom or remain in the lounge on 19 December 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel had regard to the Notice of Proposal which stated:

"C7.9. Service users had not been sufficiently supported to be actively involved in making decisions about things important to them. We saw an example of this on the second day of the inspection visit when Service User [O] was quietly resting in the lounge after lunch. Staff Member 4 approached Service User [O] without invitation and said, "You go now to bedroom, I take you now. You want to go now (followed by an unrecognisable phrase)". Before Service User [O] could answer Staff Member 4 left the room to find a wheelchair for Service User [O] to use, returned and without further comment assisted them to leave the lounge."

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel also took into account your evidence during which, when asked how you would satisfy yourself that carers would not speak to patients in the manner alleged, you stated that you had never witnessed such an incident.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, this charge is found not proved.

Charge 12a (Schedule L (5))

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule L;

5		Did not ensure that and and/or all of Staff Members 1, 3, 4 and 5 were able to communicate effectively with service users

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel had regard to the Notice of Proposal which stated:

> *"C7.3. Three service users emphasised they were concerned about Staff Members 1, 3, 4 and 5 who were not fluent in spoken English. A service user said, "I just give up some days. I won't ask for something to be done for me because they won't understand and then you have to answer a hundred and one other questions before we get to where we need to be." Another service user said, "Actually, it's quite tiring to be surrounded by staff who simply don't speak English and having constantly to repeat yourself. The other day I asked for the television remote and the member of staff switched the light on for me instead. In one way it's funny but it's not funny day after day. It's a bit like struggling to be understood in a foreign [country] - but I'm not in a foreign country I'm in what should be my home."*

The panel noted its earlier findings as in charge 3a (Schedule C (1)) that in his witness statement, Witness 2 stated that he had found there were concerns regarding staff and the use of the English language. However, in his oral evidence, Witness 2 stated that you had noticed there was an issue with the language barrier with staff and had arranged for staff members to attend an English course. Witness 2 said it "*is very unusual in residential care services"* for this to happen.

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel

previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

In your oral evidence you acknowledged there were issues with staff members not being fluent in English as it was not their first language, but that you had no concerns about their "*language capabilities"*. You said your staff did not have a good level of English, but that they were able to communicate with clients, *"adhere to their needs and they were able to respect their dignity"*. You reiterated that you had enrolled staff members onto an English course.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, this charge is found not proved.

Charge 12a (Schedule L (6))

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
a) As set out in Schedule L;

6		Did not ensure that one, or more, service user with mental capacity were provided with a key to lock their bedroom

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account your evidence.

The panel had regard to the Notice of Proposal which stated:

"C7.7. Your registered manager told us all three service users with mental capacity had been asked if they wanted to have a key to lock their bedroom door. After the inspection visit you told us there were documents showing the service users concerned had been consulted. However, when we asked these service users on the second day of the inspection visit none of them recalled having been asked about this matter. Two of the service users said they would like to have a key to their bedroom."

The panel noted that the evidence for this relies on the recollection of unknown service users as it was not specified which service users were spoken to.

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

During your evidence, you told the panel that when a resident moved into the home a decision was made with the resident and their family as to whether they would like a key.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof. Therefore, this charge is found not proved.

Charge 12a (Schedule L (7))

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule L;

7		You did not develop links with local lay advocacy resources and/or understand the need to do so

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The panel had regard to the Notice of Proposal which stated:

> *"C7.10. Your registered manager had not developed links with local lay advocacy resources and did not understand the need to do so. This increased the risk service users would not have access to the support and assistance they might need to make their voices heard."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

In addition, the panel took into account that there has been no evidence in respect of the individual residents to whom this allegation applied to or specific details of any incidents.

The panel took into account your evidence during which you stated that you did develop links with local advocacy resources for clients who had no family and friends. You stated that at the time of the inspection, all the service users had family and friends.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, this charge is found not proved.

Charge 12b

12) Failed to ensure that the Home was promoting the dignity and respect of service users and/or complied with regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term 'generally'. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 13a (Schedule M (1 and 2))

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule M;

1	K	Did not ensure that Service User K was involved./consulted in relation to their care plans in, or around, 3 months prior to the inspection on 19 December 2019
2	F	Did not ensure that Service User F was involved./consulted in relation to their care plans in, or around, 3 months prior to the inspection on 19 December 2019

These charges are found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took into account your evidence.

The Notice of Proposal stated:

"C8.3. However, in practice the arrangements to consult with service users and their relatives were poorly organised and largely ineffective. We asked Service User [K] and Service User F if they contributed to a review of their care plan in the three months preceding the inspection visit. They told us they did not recall having been consulted about their care plans. One of the service users said, "My care is just provided. The nurse might stick her head around the door and ask how I am but that's it. I don't think you mean that when you ask me about me being involved in looking at my care." Another service user said, "The care just happens. I don't have any real input into it."

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

Further, the panel noted that there is no direct evidence from Service Users K and F that they were not involved in reviewing their care plans. The panel could not identify the relevant care plans or care plan reviews for Service Users K or F, given the problem previously noted regarding the letters attached to redacted Service Users names.

During your evidence, when asked how you made sure that the service users were being consulted when their care plans were being reviewed, you answered:

> *"In the diary, we have, each month or from what I can recollect is they have the day of -- for example, I can't remember, they'll have a day when they need -- it's monthly, so they'll have the client's name in the diary to be reviewed today. So example, "Client L will be reviewed today." The time will be there. Normally, we tend to do it in the afternoon when it is quieter. In the morning, the RGN is busy, medication, doing the rounds, so always in the afternoon. Most of the time it is in the afternoon.*
> *I have witnessed where they are because I am the extra person, as the manager, I'm not the registered nurse there who's doing the job, so they will be with a client in their room doing their review."*

In response to whether you made sure staff were aware of the need to involve service users in the review, you answered*: "Yes, because that's the policy, that's how it was done. They will be reviewing the care plan with the clients themselves*."

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, these charges are found not proved.

Charge 13a (Schedule M (3, 4 and 5))

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule M;

3	D	Did not ensure that the reviews of Service User D's care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019
4	M	Did not ensure that the reviews of Service User M's care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019
5	O	Did not ensure that the reviews of Service User O's care plan was adequate and/or involved the input of relatives on one, or more, occasion between 23 October 2019 and 13 December 2019

These charges are found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal and the Nursing Care Plan Evaluation Sheets for Service Users D, M and O. It also took into account your evidence.

The Notice of Proposal stated:

"C8.2 […] Your registered manager also told us relatives of service users who did not have mental capacity were closely consulted about the care provided. […]
C8.4. We looked at the records of the reviews completed of the care plans of Service User [D], Service User [M] and Service User [O] who did not have mental capacity completed between 3 October 2019 and 13 December 2019. The records listing a total of 10 reviews showed relatives were only consulted on four occasions. The other six reviews were usually recorded by a single line. An example being the review completed on 13 November 2019 by Staff Member 1 for Service User stating, "Care plan reviewed, unchanged.""

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The evidence in respect of this charge is that contained in the Nursing Care Plan Evaluation Sheets (NCPES) for Service Users D, M and O.

The NCPES for Service User D showed that on 22 October 2019, it was recorded that *"Dressing care plan is in place, she always removed the dressing"* and on 13 November 2019 and 13 December 2019 words to the effect of "care plan reviewed, unchanged" were recorded.

The NCPES for Service User M showed that on 10 November 2019 it was recorded by Service User M's son *"I [...] am happy with mums care plan"* and on 8 December 2019 it was recorded *"care plan reviewed, it's the same".*

The NCPES for Service User O showed that on 9 November 2019 it was recorded *"care plan reviewed, unchanged"* and words to similar effect was recorded on 8 December 2019.

Your evidence was that the reviews were carried out in the service users' bedrooms and if their relatives were available and present then they would be consulted during the review.

The panel considered that there appears to be little detail provided as to the documentation of those care plan reviews. However, the panel noted that it was not provided with any evidence which confirms to what degree of detail this should have been completed. The panel did not have any evidence before it which would suggest that a lack of detail would confirm that the review was not carried out adequately.

The panel was mindful that this charge was not being pursued as a record keeping failure but was in relation to person centred care. The panel could not be satisfied that the absence of detail on the NCPES determines that the reviews were not carried out adequately and in a manner that demonstrates person centred care. Further, the panel did not have any evidence before it to be able to determine what an adequate care plan review entailed. The panel concluded that, whilst the evidence before it may suggest that the recording of the reviews in the NCPES are inadequate, there is no evidence before it to be able to conclude that the actual reviews which were carried out were inadequate.

The panel noted that there are references to family members being involved in the care plan reviews for all three service users, on earlier occasions outside of the dates set out in the charge. The panel could not be satisfied that the NMC has produced sufficient reliable evidence for it to infer that relatives were not involved in care plan reviews.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, and there being disparity between what the evidence says and what the charge alleges, the NMC have failed to discharge its burden of proof.

Therefore, these charges are found not proved.

Charge 13a (Schedule M (6))

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule M;

6		Did not ensure that information was presented to one, or more, service user in an accessible manner and/or as required by the Accessible Information Standard 2016

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took into account your evidence.

The panel noted that the Notice of Proposal stated:

> *"C8.5. Service users did not have information presented to them in an accessible manner as required by the Accessible Information Standard 2016. Care plans and risk assessments were in small print making them difficult to see. A further difficulty was they were written in a management style unlikely to engage the interests of service users. This was because most of the service users needed to have information presented in a user-friendly way using easy-read tools such as large print, pictures and graphics"*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel noted that, during your evidence you stated that you were aware of the Accessible Information Standard 2016 document and that, to the best of your ability,

you ensured the recommendations in the document were followed at the Home. You also stated that in order to ensure that the service users could see, read and understand information you would print it in different sizes. You told the panel that you were not aware of any complaints by the service users and that this was a concern that you had no knowledge of until after the inspection.

The panel noted that the only evidence the NMC relied upon for this charge was that of Witness 2. The NMC did not provide a copy of the document Accessible Information Standard 2016.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof. Therefore, this charge is found not proved.

Charge 13a (Schedule M (7))

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule M;

7	N	Did not ensure that Service User N was appropriately assisted by Staff Member 3 in relation to their food choice in, or around December 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the Notice of Proposal. It also took into account your evidence.

The panel noted that in the Notice of Proposal it stated:

"C8.6. Although there were pictures of the main dishes to help service users understand the written menu, the board on which they were displayed was hung in a little-used part of the lounge. We did not see anyone looking at it. On both days of the inspection we saw care staff speaking with service users at meal times trying to help them decide which meal they wanted to choose. However, in practice this assistance was of little value. An example was Service User [N] who only ate a small part of their lunch on the second day of the inspection. Staff Member 3 said, "You want something else, I get you sandwich, bread and something in middle." When Service User [N] asked which sandwiches were available, Staff Member 3 replied, "I get you sandwich yes and you like." After their question was not answered Service User [N] declined to make any further comment, their plate was removed and their pudding was served."

The panel noted that the information relating to this charge came from Witness 2 who exhibited the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

During your evidence, you stated that you did not know anything about this. You stated that staff always made sure that the service users had something to eat. The service users would always get and eat what they want even if it was not an item on the menu. You stated that it was a small Home and the staff, including the chef, were very kind.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, this charge is found not proved.

Charge 13a (Schedule M (8 and 9))

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule M;

8	L	Did not ensure that Service User L was appropriately supported to access support/activities during the period 19 November 2019 and 3 December 2019 – check this
9	O	Did not ensure that Service User O was appropriately supported to access support/activities during the period 19 November 2019and 3 December 2019

These charges are found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It had regard to the Home's Social Activities Participation log as an appendix. It also took into account your evidence.

The panel noted that the Notice of Proposal stated:

> *"C8.9. Your Provider Information Return says, "We treat people as individuals to meet their specific needs. Our staff assess people's individual needs (and) we support (them) in creative and imaginative ways to take part in a wide range of activities." However, we found the provision in the service to be poorly managed and of limited value. Although the activities coordinator had assessed each service user's interests these assessments did not explore imaginative ways to engage the interests of service users living with dementia. An example being the assessment for Service User [O] merely recording, "She comes to the lounge, but she is not interested in being*

involved in social activities." We examined records of eight days between 19 November 2019 and 3 December 2019 (inclusive) when small group activities had been held in the lounge. On each occasion the record for Service User [O] said, "Did not show interest." We spent time with Service User [O] and showed them pictures in a magazine to which they responded by smiling and touching the pages.

C8.10. During the same period the records for Service User [L] who did not have mental capacity had the same entries. Staff Member 5 said it was "very difficult, pretty much impossible" to engage Service User [L] in social activities. However, we were able to quickly engage Service User [L] in a visual finger-touching game when they copied a member of the inspection team by touching each of their finger-tips in turn."

The panel had regard to six of the Social Activities Participation logs between the dates of 19 November 2019 and 5 December 2019. The activities noted on those dates were that the residents were visited and chocolates were brought for them, "*photo showing chatting about countries", "tea, scones and music afternoon", quiz on general knowledge, Christmas tree in lounge put up with music or Christmas music in service users bedroom, mince pies and ball catching or chat in service users room and "making xmas cards".* For all six dates, in the participation section, for Service Users O and L it stated, *"did not show interest".*

During your evidence, when asked whether you made sure an alternative activity was offered for Service User L, you stated that there were different activities that the service user had to choose from, and these were encouraged but you could not force the service users to participate in the activities. You stated that Service User L was offered different activities and yet showed no interest in any of them. You stated that service user O just wanted to be left alone and informed the panel that she was 101 years old and just wanted to be left to rest.

Taking into account all of the evidence before it, the panel determined, the NMC have failed to discharge its burden of proof as there was evidence to suggest the service users were supported and had chosen not to participate. Therefore, these charges are found not proved.

Charge 13b

13) Failed to ensure that the Home provided person centred care and/or complied with regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 14a (Schedule N (1))

14) Failed to ensure that the Home effectively received/handled complaints and/or complied with regulations 16(1) and 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule N;

1		Did not ensure that your complaints policy and procedures were accessible to one, or more, service users

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C9.2. Although there was a complaints procedure it was written in small print and presented information in a formal management style. When we were speaking with Service User F in their bedroom they picked up a television guide that had print of a similar size to the complaints procedure. Service User F soon put the guide to one side and said, "I can't even begin to read that."*

The information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

During your evidence, you stated that the complaints policy was made accessible to the service users who had capacity and that a family member could put their complaint in writing. You stated that for those who could not write, they could make verbal complaints and that each service user had a copy of the complaints policy in their bedroom. If they required a larger print for example, this would be provided to them.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof. Therefore, this charge is found not proved.

Charge 14a (Schedule N (2))

14) Failed to ensure that the Home effectively received/handled complaints and/or complied with regulations 16(1) and 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule N;

2	K	Did not ensure that Service User K's complaint relating to food between September 2019 and November 2[0]19 was appropriately investigated and/or resolved

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C9.5. We examined records of two complaints you received between September 2019 and November 2019 (inclusive). One of the complaints was from Service User [K] who said they wanted more choice of fillings in the sandwiches served at tea time. The record of the resolution of the complaint stated Service User [K] was told there was a variety of fillings available each day. It did not show why Service User [K] had not been offered a choice to that point and did not indicate an apology was offered. In addition, the record did not describe any follow-up actions such as checking with Servicer User [K] afterwards to make sure the matter remained resolved to their satisfaction.*

After the inspection visit you told us a new system had been introduced with the chef visiting service users in their bedrooms each day to check which dishes they wished to be offered. However, you did not submit any evidence to confirm the operation of the new arrangement."

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel had regard to the Home's complaint form for Service User K which stated:

"Service User K […] is fed up with cheese sandwiches everyday. He wants to have more variety on offer."

The complaint form indicated that the action taken by the Home in response to this complaint was immediate and an alternative sandwich option was provided to Service User K for that meal.

During your evidence, you stated that when Service User K had complained about the food offered, alternatives were always provided. You stated that you tried to talk to Service User K and his nephew and informed the panel that Service User K only complained about certain meals.

Taking into account all of the evidence before it, the panel determined that the NMC have failed to discharge its burden of proof. The evidence before it showed Service User K's complaint relating to food was appropriately investigated and resolved in a timely manner. Therefore, this charge is found not proved.

Charge 14a (Schedule N (3))

14) Failed to ensure that the Home effectively received/handled complaints and/or complied with regulations 16(1) and 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

a) As set out in Schedule N;

3	O	Did not ensure that a complaint on behalf of Service User O relating to wheelchair positioning between September 2019 and November 2019 was appropriately investigated and/or resolved

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C9.6. The second complaint had also not been managed in the right way. A relative had been concerned Service User [O] had been left sitting in an uncomfortable position in a wheelchair in the lounge. Parts of the record of the resolution of the complaint were illegible. However, the information we could read did not explain what lessons had been learned to ensure Service User [O] was not left again to sit in a wheelchair for an extended time. We asked your registered manager about the lessons learned and they were not able to give us any further information."*

The panel had regard to the Home's complaint form for Service User O which does not refer to complaints about the wheelchair positioning or any discomfort that Service User O was experiencing. The complaint form indicated that the complaint was made in a face-to-face conversation with Service User O's relatives. The issues raised did not relate to the position of the wheelchair and they appeared to be resolved immediately.

During your evidence, you stated that, from your recollection, when you spoke to the staff at the Home about the complaint raised by Service User O's relatives, it related

to her not having had her pudding after dinner as she was a slow eater and that was why she remained at the dining room table. You stated that the Home spoke to the family of Service User O at the time and reassured them that Service User O was not forgotten.

The panel did not hear evidence from Service User O or their family members.

Taking into account all of the evidence before it, the panel determined that the NMC have failed to discharge its burden of proof. The panel determined that the charge alleges a complaint relating to the position of the wheelchair, but the evidence of the complaint makes no reference to any issues with the position of the wheelchair.

Therefore, this charge is found not proved.

Charge 14b

14) Failed to ensure that the Home effectively received/handled complaints and/or complied with regulations 16(1) and 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of

and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 15a (Schedule O (1))

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
a) As set out in Schedule O;

1		Did not ensure that robust systems and processes to assess monitor and improve the quality and safety of the service were established as at 19 December 2019

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection, the Notice of Proposal and the notes of the meeting with CQC in September 2019 as an appendix. The panel also took into account Witness 3's evidence and your evidence.

The Notice of Proposal stated:

"C10.2. At the inspection on 19 December 2018 you had not established robust systems and processes to assess, monitor and improve the quality and safety of the service. We found that quality checks had not been completed or had not been effective. This had resulted in shortfalls in your service not being quickly resolved. In addition, you had not fully consulted with service users about the development of the service"

As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

However, the panel took into account that Witness 3 was present at the CQC meeting which took place in September 2019 and on one day of the December 2019 CQC inspection. Witness 3 was Witness 2's line manager and oversaw his work.

The panel heard evidence from Witness 3 in relation to the September 2019 meeting. She stated:

"From reading the minutes and from understanding the inspections that had taken place and the ratings, it would have been to meet with the registered manager to discuss ongoing concerns about the breaches of regulation and the ratings. And to outline what our options were that were available to us, what might happen if the rating didn't improve and if the home remained in breach of regulation."

In relation to the December 2019 inspection, Witness 3 went on to state:

"[…] the dealings that I'd had with Mrs Persand were through the meeting that we had and then the subsequent inspection. Mrs Persand was always very passionate about her service but didn't always understand the requirements of the regulations and wasn't always particularly organised in her approach to managing the care home. And that, I believe, led to a lot of the breaches of regulation.

[…]

My concerns were the ongoing non-compliance with regulation. So this was a service that had been in breach of regulation at various points over quite a long period of time. And sometimes the issues would be addressed, but for quite a short period of time, and then the standards would drop back again. So it required a lot of input from the regulator in order for standards to improve. And when we stepped away, those standards would fall again.
So my main concern, was the ongoing breach of regulation and the impact that that was having on people using the service. And this was a group of very vulnerable older people who required care and some people required nursing support. And the concerns were around the impact that was having on them and their care.
[…]
Yeah, so there we -- I was concerned about the risk of harm due to incidents in the home, such as a fire and staff not knowing how to respond. Concerns around how they were managing the risk of people who could choke because of their swallowing difficulties. I was concerned about medicines practice. I was concerned about the lack of staff who were suitably skilled and qualified to meet people's needs and the recruitment practices within the home to make sure that staff were suitable to work with people.

People themselves were telling us that the home was quite poorly organised and the care they received was inconsistent. And I was concerned that the registered manager and registered provider didn't have good oversight of the service. So they weren't making the improvements that we expected them to make and they weren't managing the service appropriately. "

During your evidence, you were referred to the notes of the meeting with the CQC in September 2019 where the NMC suggest the concerns in respect of this charge were put to you. You stated that you could not recall this meeting or what was said during it.

The panel took into account all of the evidence before it, in particular the evidence from Witness 3 who was present at the September 2019 meeting and for one day as part of the December 2019 inspection. It concluded that there is sufficient evidence

from Witness 3 before it which shows that you did not ensure that robust systems and processes to assess, monitor and improve the quality and safety of the service were established as at 19 December 2019. The panel therefore finds this charge proved.

Charge 15a (Schedule O (2))

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
a) As set out in Schedule O;

2		Did not ensure that adequate audit relating to medicines management were undertaken as at the date of the inspection on 19 December 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C10.7. Your registered manager told us they completed a comprehensive monthly audit of the management of medicines in your service. However, the arrangement was not up to date as the most recent audit was dated 3 November 2019. Although the audit covered a number of key subjects it had not been completed in a robust way and was of little value. It had not identified any of the shortfalls we found relating to planning and recording the administration of medicines."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

During your evidence, you stated that a monthly audit of the medications was carried out. You stated that every month the audits were completed and that there would not be any shortfall at all in the dates as it was always recorded in the diary.

The panel had regard to the audit dated 3 November 2019 which was 11 pages long. However, the panel was not provided with any evidence as to why this audit was deemed inadequate and not '*completed in a robust way'*.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, this charge is found not proved.

Charge 15a (Schedule O (3))

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
a) As set out in Schedule O;

3		Did not ensure that service users were consulted regarding the development of the service

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the

December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C10.8. We found that you had not suitably involved service users and their relatives in making suggestions about how your service could be improved. Your Provider Information Return said service users were invited to attend regular 'residents' meetings' to give feedback about their experience of receiving care in your service. However, the record of the meeting held on 2 December 2019 showed that only four service users chose to attend and little had been done to engage these service users in a meaningful consultation exercise. An example of this was the very brief and only entry in the record summarising Service User [L]'s contribution to the meeting saying, "When (the activities coordinator) speaks to her she always seems content. She will always smile.""*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel had regard to the Home's Residents' Meeting minutes of 2 December 2019 which demonstrated how the Home's residents were consulted. The panel noted that this meeting was conducted by another member of staff, the meeting occurred in the lounge area of the Home and four service users attended. The minutes stated:

> *"I […] had an individual meeting with the resident's in their bedrooms as they did not want to attend the lounge and wanted to know how things are living here at Abbey Court and if they have any concerns that they would like to raise."*

The panel took into account that the staff member conducting the meeting also recorded comments from three service users who were consulted in their bedrooms.

During your evidence, you stated that there were only four service users (out of ten) at this meeting because the other service users wanted to stay in their bedrooms. You stated that the way you ensured those service users who preferred to stay in their rooms were given the opportunity to be involved in the residents' meetings was by having individual meetings occur in their rooms so that they could raise any concerns.

The panel determined that there is evidence before it to show that the service users were consulted by the Home. However, it did not have any evidence before it to determine what degree of consultation was required to be '*meaningful'* or adequate.

Taking into account all of the evidence before it, the panel determined that the NMC have failed to discharge its burden of proof. Therefore, this charge is found not proved.

Charge 15a (Schedule O (4))

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
a) As set out in Schedule O;

4		Did not ensure that any and/or all of Staff Members 1, 2, 3, 4 and 5 were suitably supported/trained to understand their responsibilities and provide safe and effective care

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the

December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C10.13. Staff Members 1, 2, 3, 4 and 5 had not been suitably supported to understand their responsibilities to meet regulatory requirements. Although there were written policies and procedures designed to help nurses and care staff provide the right care, Staff Members 1, 2, 3 and 4 did not know where to find the documents or what subjects they covered. When we asked Staff Member 4 about their use of your policies and procedures they said, "I not know what you mean. I read care plan after care plan and I know what I need. No read office documents as not need."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence. In addition, the panel did not hear evidence from staff members 1, 2, 3, 4 and 5.

During your evidence, you informed the panel that all staff had an induction, and you made sure that staff were aware of where to find the policies and that they were on the nursing station where, every morning and every afternoon, the handover takes place. You stated that the policies were on the shelf open for the staff to see and accessible to them all.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, this charge is found not proved.

Charge 15a (Schedule O (5))

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule O;

5		Did not ensure that effective 'handover' of care was provided/implemented

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C10.14. Your registered manager told us it was important to have detailed handovers between shifts so nurses and care staff knew about any changes in the care to be provided. We were also told these handover meetings were recorded so nurses and care staff could refer to the information they had been given. However, when we asked to see these records we were only given a single undated sheet of paper. The only information on the sheet was service users' dates of birth and dates of admission to the service. Staff Member 3 and Staff Member 4 did not understand what was meant when we asked about their contribution to handover meetings. Staff Member 3 said, "What I have to handover what you want me give you. I give people here what they want. Not need write down what I give." Staff Member 2 said, "I just come on shift, head down and get on with it. There's so much to do."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel

previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence. In addition, the panel did not hear evidence from any of these staff members.

The panel was not provided with any evidence, oral or documentary, which informed it of what an effective handover consisted of or what the documentation for an 'effective' handover should consist of.

The panel had regard to one of the Home's Handover sheets which was not dated and was heavily redacted and consequently only showed the anonymised service users names. Therefore, this document did not assist the panel in determining this charge.

During your evidence, you stated that the handovers occurred the same way each day and took place at the nurse's station with the attendance of the staff on shift. You explained that you would expect to see the basic information of what had occurred on the day on a handover sheet. You stated that you checked over handover sheets and had never identified any concerns with the level of detail as other documentation is also completed including a diary that is kept for each day.

Taking into account all of the evidence before it, the panel determined, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof.

Therefore, this charge is found not proved.

Charge 15a (Schedule O (6))

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    a) As set out in Schedule O;

6	K	Did not ensure that the care plan audit completed on 20 May 2019 identified/addressed shortfalls relating to arrangements for Service User K to drink safely

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C10.6. […] Another example was the care plan audit completed on 20 May 2019 for Service User [K]. It did not identify shortfalls in the arrangements used to support Service User [K] to drink safely […] Other shortfalls in the provision of care not rectified due to inadequate quality checks included catheter-care, reducing the risk of dehydration and the provision of person-centred care."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel had regard to the care plan for Service User K as well as a document which was exhibited as the care plan audit for Service User K dated 20 May 2019. However, the panel could not conclude that this care plan audit was for Service User K as the service user ID field was redacted in the process of the CQC's investigation. It therefore could not conclude that the contents of this care plan audit was relevant to Service User K.

During your evidence, you stated that you or Registered Nurse 2, who also worked at the Home, were the people who conducted the audits. You stated that when

Registered Nurse 2 conducted the audit, you did a check to make sure it was completed but did not review the audit itself. You accepted that it was ultimately your responsibility to ensure that care plans were being reviewed as required. You stated that you were confident that the policy was being followed in respect of the care plan reviews as you had witnessed them being conducted with your own eyes. You stated that the most important thing is that the care plan was reviewed, and you knew that the staff were completing the care plan reviews with the service users.

Taking into account all of the evidence before it, the panel determined that, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof. The panel could not identify any documentary evidence of Service User K's care plan audit. There was no evidence to support the charge that Service User K's care plan audit did not identify or address shortfalls. Therefore, this charge is found not proved.

Charge 15a (Schedule O (7))

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
a) As set out in Schedule O;

7	L	Did not ensure that the care plan audit completed on 20 May 2019 identified/addressed the unsafe practice relating Service User L being transferred by hoist

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account your evidence.

The Notice of Proposal stated:

> *C2.12. We found that service users with reduced mobility were not assisted to transfer in a safe way. Your registered manager told us two members of staff were needed to safely operate the sling hoist when service users were being assisted to transfer. This was because one member of staff needed to operate the mechanism of the hoist while their colleague helped the service user to maintain their seated position so as not to compromise the sling's load-bearing straps. The care plan for Service User [L] said two staff were needed when Service User [L] was transferred with the hoist. However, Staff Members 2 and 4 said they sometimes ignored this safety requirement and assisted Service User [L] to use the sling hoist on their own to save time.*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence. Further, the panel noted that the risks identified by Witness 2 in the Notice of Proposal relate to December 2019 which is 7 months after the time of the alleged charge. The panel was not provided with evidence that demonstrated how Registered Nurse 2 could have identified those concerns at the time of his audit in May 2019. In addition, the panel did not hear evidence from staff members 2 and 4.

The panel considered the Summary of Occupational Therapy Intervention but noted that this document did not specify any service users' names and therefore could not assist with this charge.

The panel also had regard to the care plan for Service User L which states:

> *"I will need the staff to support me with my mobility. I am chair/bed bound. I cannot weight bear. I should be transferred with a full body hoist using medium slink* [sic] *with the help of two staff"*

During your evidence, you stated that you or Registered Nurse 2 conducted the audits. You stated that when Registered Nurse 2 conducted the audit, you did a check to make sure it had been done but did not review this individual audit. You accepted that it was ultimately your responsibility to ensure that care plans were being reviewed as required. You stated that you were confident that the policy was being followed in respect of the care plan reviews as you had witnessed them being conducted with your own eyes. You stated that the most important thing is that the care plan was reviewed, and you knew that the staff were completing the care plan reviews with the service users.

In addition, the panel was provided with what was exhibited as the care plan audit for Service User L. However, when reviewing this document, the panel noted that the service user ID field was filled out with the details of a different Service User. It therefore could not be satisfied that the information within this document related to that of Service User L.

Taking into account all of the evidence before it, the panel determined that, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof. Therefore, this charge is found not proved.

Charge 15a (Schedule O (8))

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
a) As set out in Schedule O;

8	D	Did not ensure that the care plan audit completed on 27 December 2019 identified/addressed the need for Service User D to be transferred using an ‘in-situ’ sling

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the CQC inspection report relating to the December 2019 inspection and the Notice of Proposal. It also took account of your evidence.

The Notice of Proposal stated:

> *"C2.14. A document in the service and copied to the Care Quality Commission said an occupational therapist had recommended Service User [D] use an 'in-situ' sling to make it safer and more comfortable for them to transfer. This was because the in-situ sling avoided the need for care staff to partially lift and reposition Service User [D] before the hoist could be used. In turn, this reduced the risk Service User [D] would be jolted or dropped during the positioning operation. However, your registered manager and Staff Members 1 and 3 were not aware the advice had been given and no action had been taken to obtain a new in-situ sling. As a result, a conventional sling remained in use for Service User [D] who continued to have to be partially lifted and repositioned when this should have not been necessary."*

The panel noted that the information relating to this charge came from Witness 2's CQC inspection report and the Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel had regard to the Summary of Occupational Therapy Intervention and noted that this document did not identify which service users it referred to.

The panel had regard to a document which was exhibited as the care plan audit for Service User D. However, the panel could not conclude that this care plan audit was for Service User D as the service user ID field was redacted by the CQC. It therefore could not conclude that the contents of this care plan audit was relevant to Service User D. In addition, the panel noted that this care plan audit was dated 27 December 2019 which was after the CQC inspection which reported this concern.

During your evidence, you stated that you or Registered Nurse 2 who also worked at the Home were the people who conducted the audits. You stated that when Registered Nurse 2 conducted the audit, you did a check to make sure it had been done but did not review this individual audit. You accepted that it was ultimately your responsibility to ensure that care plans were being reviewed as required. You stated that you were confident that the policy was being followed in respect of the care plan reviews as you had witnessed them being conducted with your own eyes. You stated that the most important thing is that the care plan was reviewed, and you knew that the staff were completing the care plan reviews with the service users.

Taking into account all of the evidence before it, the panel determined that, as a result of there being no further evidence to corroborate the evidence exhibited by Witness 2 to support this charge, the NMC have failed to discharge its burden of proof. Therefore, this charge is found not proved.

Charge 15b

15) Failed to ensure that the Home exercised good governance/operated effective systems and processes to ensure compliance with the requirements of the regulations and/or complied with regulations 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 16a (Schedule P (1))

16) Failed to ensure that you/the Home notified the CQC of notifiable incidents and/or complied with regulations 18 of the Care Quality Commission (Registration) Regulations 2009
    a) As set out in Schedule P;

1	N	Did not notify the CQC of allegations brought to you attention by Kent County Council that on, or around 22 October 2019, that Staff Member 2 has been speaking to Service User N in an offensive/threatening/sexual manner

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the Notice of Proposal and Witness 1's evidence. It also took account of your evidence.

The Notice of Proposal stated:

"C11.3. Since the last inspection you have not submitted at least two notifications to us in accordance with the regulations. One of these incidents referred to your receipt of an allegation of abuse that Staff Member 2 spoke with Service User [N] *in an offensive, threatening and sexual manner. The other incident referred to your dismissal of Staff Member 2 for gross misconduct on the first day of the inspection."*

The information relating to this charge came from Witness 2's Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel found that Witness 1 was a reliable and credible witness. Witness 1 told the panel she could not remember the name of the carer and therefore could not assist the panel with whether or not it was Staff Member 2.

The panel noted that you had dismissed Staff Member 2 in December 2019, but you did not agree that you were made aware of any incident in October 2019.

The panel determined that the NMC did not make its case that the carer identified was Staff Member 2.

The panel determined that the NMC had not discharged its burden of proof. It therefore finds that this charge is not proved.

Charge 16a (Schedule P (2))

16) Failed to ensure that you/the Home notified the CQC of notifiable incidents and/or complied with regulations 18 of the Care Quality Commission (Registration) Regulations 2009
   a) As set out in Schedule P;

2		Did not notify the CQC of Staff Member 2's dismissal

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's evidence, including his two witness statements, which exhibited the Notice of Proposal. It also took account of Witness 3's evidence and your evidence.

The Notice of Proposal stated:

> *"C11.4 At the end of the second day of the inspection visit we reminded you about the need to submit the notifications in question because they related to incidents where service users had been subjected to abuse. By the date of this Notice of Proposal you have failed to comply with this legal requirement."*

The information relating to this charge came from Witness 2's Notice of Proposal. As established by the panel previously, it has already identified that it cannot place much weight on Witness 2's evidence as he undermined his own evidence.

The panel did not receive any evidence to show how you should have notified the CQC about Staff Member 2's dismissal.

Witness 3 in her site visit notes dated 17 December 2019 and written at the time stated:

> *' I asked* [the Registrant] *to confirm that SM2s' shifts would be covered and to let me know when SM2 was removed from the Home.*
> *…*
> *[the Registrant] advised that she had spoken to SM2 and he was leaving the premises.'*

During your evidence, you did not accept that you were told about the incident set out in Schedule P (1) in October 2019. You informed the panel that you had found out about it from the CQC during the December 2019 inspection and had dismissed Staff Member 2 the same day. Your evidence was that because the incident was raised with you by Witness 3 a senior manager at the CQC and that you informed them of your subsequent actions, you did not need to do anything further.

Therefore, the panel determined that the NMC had not discharged its burden of proof. It finds this charge not proved.

Charge 16b

16) Failed to ensure that you/the Home notified the CQC of notifiable incidents and/or complied with regulations 18 of the Care Quality Commission (Registration) Regulations 2009
b) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 17a (Schedule Q (1))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

1		Did not ensure that the Home was free from trip hazards, in that there was a hole in the floor and/or the carpet needed replacing

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report of May 2019, the Kent County Council's Service Improvement Plan dated 30 May 2019 for the Home and Witness 1's evidence. The panel also took into account your evidence.

The panel had regard to Witness 1's witness statement which stated:

> *"There was a hole in the floor in the corridor which was being covered by a mat. It was determined that both the mat and the hole posed a trip hazard to the residents and that the carpet needed to be replaced."*

The panel took into account that the Kent County Council Inspection Report of May 2019 stated:

> *"Some improvements have been made to the home, new flooring has been put in the corridor however, there is a mat covering a hole in the floor in one of the corridors. Both the mat and the hole pose a trip hazard and the carpet needs to be replaced."*

The panel bore in mind that the Kent County Council's Service Improvement Plan indicated that the maintenance which needed to be carried out in the Home was that the carpet needed to be replaced.

During her evidence, Witness 1 stated that she had observed the hole in the floor herself and recalled spotting it after seeing a mat on the floor just outside of your office. She stated that she noticed the mat because when looking at residential nursing homes for older people, she was always looking for trip hazards to make sure that where possible the flooring is at the same level. She described the hole as being approximately 15 centimetres wide.

During your evidence, you accepted that you had covered a dent in the corridor with a mat and you explained that this was a temporary measure until you could get the external personnel to come and complete the work.

The panel determined that Witness 1 was a credible and reliable witness. The panel found that Witness 1's oral evidence has been consistent with her written evidence. The panel concluded that Witness 1's evidence was also supported by the Kent County Council's Inspection report and the Improvement Plan. The panel also took into account that you accept there being a hole in the floor.

Taking account of all the information before it, the panel concluded that there is sufficient evidence before it to conclude that you did not ensure that the Home was free from trip hazards, in that there was a hole in the floor and/or the carpet needed replacing. The panel therefore finds this charge proved.

Charge 17a (Schedule Q (2))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
    a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

2	M	Did not ensure that Resident M's care plan provided appropriate information in relation to: a) SALT/diet and risk of choking; b) Hearing; c) Skin integrity

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report of May 2019, the Kent County Council's Service Improvement Plan for the Home dated 30 May 2019 and Witness 1's evidence. The panel also took into account your evidence.

Witness 1's evidence established that the duty was on you, as the Registered Manager of the Home, to provide an appropriate standard of care and comply with the terms of a contract commissioned by Kent County Council. She stated:

> *"the registered manager will be the responsible for the running of the home, overseeing the home. They'll obviously have staff reporting into them that will deliver the care and support. But overall they'll be responsible for ensuring that sufficient staffing, ensuring that people are getting the support that they need. Different homes manage processes differently. Some people write the care and support. Some home managers write the care and support plan plans. Some give that task to someone else, but they ultimately will be responsible for all of those plans and making sure they're delivered. And meeting all the legal and statutory requirements that a registered home needs to.*
> *[…] we would expect the registered manager to have a process to audit all of the record keeping. So like I said, different organisations choose to do it differently. On this -- in this home, Mrs Persand took responsibility for the support plans and the risk assessments, and I believe the staff were responsible for the Daily Care notes. But we would absolutely expect the home manager to have oversight of those care notes. And to have an audit trail so that some could be looked at to ensure that the quality was sufficient. You know, generally have oversight of what staff were recording, that kind of thing."*

The panel had regard to Witness 1's witness statement which stated:

"Resident Service User M was referred to Speech and Language Therapy ('SALT'). SALT will review the patient and provide guidance as to their needs. SALT noted that Service User M was a high risk of choking due to concerns with her swallowing, and they provided guidelines which indicated that Service User M should be placed on a pureed diet. It was noted that while this was referred to in the care plan review notes, it had not been referred to in the main body of the care plan. We were concerned by this as we would expect care plans to clearly show how the person should be supported, and in order to achieve this we would expect guidance from professional teams to be included within the care plans. Further, it was noted that Service User M skin integrity care plan required to be updated. On review, her care plan did not include updates around her glasses and hearing aids, and (as above) also had not been updated to include the SALT guidelines. It was believed that this was a serious risk;"

The panel took into account the that the Kent County Council Inspection Report of May 2019 stated:

"Care Plans are in place but lack detail and important information. For example, one resident has seen SALT who has recommended that they are put onto a pureed diet, this was referred to in the care plan review notes whereas it should be in the main body of the care plan. Care plans should be regularly reviewed and updated when there are significant changes with someone's care.
Service User M's skin integrity plan needs to be updated. Her care plan does not include updates required around her glasses and hearing aids. Her care plan has not been updated to refer to SALT guidelines which is a serious risk."

The Kent County Council's Service Improvement Plan indicated that concerns were identified in respect of the Home's care planning. Under action to be taken, it recommended that all care plans should reference SALT guidelines where appropriate. These needed to be reviewed when there is significant change and updated with relevant care information. The panel noted that the Service Improvement Plan did not make reference to the specific service users which the concerns identified related to, but it took into account that the concerns are relevant to what is set out in this charge.

In respect of Resident M's care plan, Witness 1 stated:

> "*there was a lot of concerns around the management of choking risks at this home. Because the care and support plans weren't -- we didn't feel they were accurate in terms of people's swallowing needs. So the fact that we knew there was a number of those residents that needed to be observed and they weren't, we did discuss that with her. I wouldn't have said the response was -- I'm, I'm not sure whether Mrs Persand understood the severity of the situation. There, there wasn't really a response, really. We discussed it and we discussed that it wasn't what we would expect."*

During Witness 1's evidence, she informed the panel that the inspection undertaken by her was completed alongside Person 1. Witness 1 informed the panel that Person 1 would have had sight of the care plans and Person 1 would have shared these with her. She stated:

> *"So I, as the commissioner takes the lead, we'll write the report. We'll ask for notes from who we're attending with from their perspective. And we'll combine that feedback, and then we'll send them a copy of the draft report. Ensure that they're happy with it, and then it'll be sent to the provider for the same process.*
>
> *so on the 30 May I visited with Person 1. She was a senior practitioner so she would have been a social worker. So when we visit, we like to visit with a member of commissioning and then what we call an operational, so a trained social worker, a registered practitioner. So she would have been looking at the care and support plans.*
> *[…]*
> *I used to write care and support plans. But Person 1 is the registered practitioner, so in this capacity now, I was looking to her. She picked it up, but she did share it with me, and we sat and had a discussion about what we'd expect."*

During your evidence, you stated that you could not remember what the care plan for Resident M stated but that if there was a hearing problem, it would be identified in the care plan. You stated that updating the skin integrity plan was the job of the registered nurse. You stated:

> *"Skin integrity, they do monthly but for some of them, they had -- if they had any dressings or anything, they would have been done each time there's a dressing. Thinking about it, there was a plan to check -- I can't recall if there was something to be checked in daily -- I think there is something they have to write in their notes about their skin. Yes, there was something in that manner on a daily -- but daily."*

You stated that you had checked personally whether skin integrity plans had been updated when there had been pressure sores or when there had been concerns.
In respect of the SALT diet and risk of choking, you stated that you would leave it to the registered nurse to ensure the guidance given by the SALT team was documented within the care plan and you would have oversight of it.

In relation to the allegation that Resident M's care plan did not provide appropriate information about the SALT diet and risk of choking, the panel found that this was supported by Witness 1's written statement, the Kent County Council Inspection report, the Service Improvement Plan and Witness 1's oral evidence.

In relation to the allegation that Resident M's care plan did not provide appropriate information about Resident M's hearing, the panel found that this was supported by Witness 1's written statement and the Kent County Council Inspection report.
In relation to the allegation that Resident M's care plan did not provide appropriate information about Resident M's skin integrity, the panel found that this was supported by Witness 1's written statement and the Kent County Council Inspection report.

The panel determined that Witness 1 was a credible and reliable witness. The panel found that Witness 1's oral evidence has been consistent with her written evidence and that she relied on the observations she made when reviewing care plans with

Person 1. The panel concluded that Witness 1's evidence was also supported by the Kent County Council's Inspection report and the Improvement Plan.

Taking account of all the information before it, the panel determined that there is sufficient evidence before it to conclude that, on the balance of probabilities, you did not ensure that Resident M's care plan provided appropriate information in relation to a SALT/diet and risk of choking, hearing and skin integrity. The panel therefore finds this charge proved in its entirety.

Charge 17a (Schedule Q (3))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

3	J	Did not ensure that in relation to Resident J: a) their falls record consistently matched the accident recordings log within the Home; b) a self- harming risk assessment was in place; c) their eating and drinking SALT Guidelines were included in their care plans

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report dated May 2019, the Kent County Council's Service Improvement Plan for the Home dated 30 May 2019 and Witness 1's evidence. The panel also took into account your evidence.

As the panel found in charge 17a (Schedule Q (2)), Witness 1's evidence established that the duty was on you, as the Registered Manager of the Home, to provide an appropriate standard of care and comply with the terms of a contract commissioned by Kent County Council.

The panel had regard to Witness 1's witness statement which stated:

> *"Service User J falls record did not consistently match the accident recordings. To explain, the Home had a general accident/incident log in place and then also had a falls record in the individual care files. When we compared these logs, the information did not match. It was also noted that Service User J did not have a falls risk assessment in place. Further, it was noted in the care records that Service User J had self-harmed in the past, but there was no risk assessments around this in place.*
>
> *In addition to this, it was found that Service User J's eating and drinking SALT guidelines were not reflected within her care plans – however, I am not able to recall what Service User J's specific needs were. […]"*

The panel took into account the that the Kent County Council Inspection Report of May 2019 stated*:*

> *"Service User J's falls records did not consistently match the accident recording and there was no falls risk assessment. Her eating and drinking guidelines were not updated within the care plan according to SALT guidelines.*
> *[…]*
> *Service User J's record's say that she has self harmed in the past but there are no risk assessments around this."*

The Kent County Council's Service Improvement Plan indicated that concerns were identified in respect of the Home's risk assessments, care planning as well as accident and incident reporting. Under 'action to be taken', the improvement plan recommended that all care plans should reference SALT guidelines where appropriate, needed to be reviewed when there is significant change and updated with relevant care information. The Service Improvement plan also recommended that risk assessments needed to be sufficiently completed for all risks identified per resident. A further recommendation was that staff and resident incident reporting should be separate and that incidents should be reported and consulted with

safeguarding as appropriate. The panel noted that the Service Improvement Plan did not make reference to the specific service users which the concerns identified related to but it took into account that the concerns are relevant to what is set out in this charge.

As referred to in the panel's decision for charge 17a (Schedule Q (2)), during Witness 1's evidence, she informed the panel that the inspection undertaken by her was completed alongside Person 1. Witness 1 informed the panel that Person 1 would have had sight of the care plans and Person 1 would have shared these with her.

The panel found that Witness 1's written statement addresses these allegations and was consistent with the Kent County Council's Inspection report and Service Improvement Plan.

During your evidence, you stated that you would leave the registered nurse to ensure that guidance given by the SALT team was in the service user care plans and you would have oversight of this.

In relation to a self-harming risk assessment being in place, you stated that you were aware Service User J had previously self-harmed when she was young. You stated:

> *"When she was young, she was in her -- I can't remember how old she was, she was young and she'd never self-harm in the home. Why would we create something which is not there? We need to focus on things which are there, eg her sleeping in a bed."*

In relation to Resident J's falls record consistently matching the accident recordings log within the Home, the panel found this allegation was supported by Witness 1's written statement, the Kent County Council Inspection report, and the Service Improvement Plan.

In relation to a self- harming risk assessment not being in place for Resident J, the panel found this allegation was supported by Witness 1's written statement, the Kent County Council Inspection report, and the Service Improvement Plan.

In relation to SALT guidelines not being included in Resident J's care plan, the panel found this allegation was supported by Witness 1's written statement, the Kent County Council Inspection report, and the Service Improvement Plan.

The panel determined that Witness 1 was a credible and reliable witness. The panel found that Witness 1's oral evidence has been consistent with her written evidence and that she relied on the observations she made when reviewing care plans with Person 1. The panel concluded that Witness 1's evidence was also supported by the Kent County Council's Inspection report and the Improvement Plan.

Taking account of all the information before it, the panel determined that there is sufficient evidence before it to conclude that, on the balance of probabilities, you did not ensure that, in relation to Resident J, their falls record consistently matched the accident recordings log within the Home, a self- harming risk assessment was in place and their eating and drinking SALT Guidelines were included in their care plans. The panel therefore finds this charge proved in its entirety.

Charge 17a (Schedule Q (4))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
    a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

4	O	Did not ensure that in relation to Resident O: a) their care plan reflected the occupational therapy recommendation; b) their care plan reflected how their skin integrity should be managed

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report dated May 2019, the Kent County Council's Service Improvement Plan for the Home dated 30 May 2019 and Witness 1's evidence. The panel also took into account your evidence.

As the panel found in charge 17a (Schedule Q (2)), Witness 1's evidence established that the duty was on you, as the Registered Manager of the Home, to provide an appropriate standard of care and comply with the terms of a contract commissioned by Kent County Council.

The panel had regard to Witness 1's witness statement which stated:

> *"Service User O care plan did not reflect the occupational therapy recommendations and it was noted that the care plans did not reflect clearly how Service User O's skin integrity should be managed. However, I am not able to recall this resident's care needs. This was concerning as it was noted that Service User O was a high risk."*

The panel took into account that the Kent County Council Inspection Report of May 2019 stated:

> *"Service User O's care plan does not reflect OT recommendations and it is not clear how her skin integrity should be managed given that she high risk."*

The Kent County Council's Service Improvement Plan indicated that concerns were identified in respect of the Home's care planning and, under action to be taken, the improvement plan recommended that care plans needed to be reviewed when there is significant change and updated with relevant care information. The panel noted that the Service Improvement Plan did not make reference to the specific service users which the concerns identified related to, but it took into account that the concerns highlighted in the improvement plan are relevant to what is set out in this charge.

As referred to in the panel's decision for charge 17a (Schedule Q (2)), during Witness 1's evidence, she informed the panel that the inspection undertaken by her was completed alongside Person 1. Witness 1 informed the panel that Person 1 would have had sight of the care plans and Person 1 would have shared these with her.

During your evidence, when asked whether care plans should be the result of working in a multi-disciplinary manner to include input from a range of different professional staff and stakeholders, you answered:

> *"The answer is yes and no. […] the answer to your question is yes and no, but it was just a recommendation.*
> *[…] I would have addressed it with her when she come next time. So we would put it in practise, which is yes. And if it's not working, we're not going to carry on."*

You also stated that to your knowledge, Service User O's care plan did reflect the skin integrity concerns and how they were managed. You stated that you disputed the comments in the Inspection Report about Service User O's care plan and stated:

> *"Maybe it wasn't clear, but we were managing it. I don't know. I mean, the care plan, as I say, is done by the nurse."*

You stated that you do not know how to respond to the comment about the care plan not reflecting the OT recommendations as *"all the recommendation would have been put in place in that care plan."* You stated that for you, the care plan was clear, but from an outsider's point of view it may not have been clear enough.

In relation to the Occupational Therapy recommendation not being included in Resident O's care plan, the panel found this allegation was supported by Witness 1's written statement, the Kent County Council Inspection report, and the Service Improvement Plan.

In relation to how their skin integrity should be managed not being included in Resident O's care plan, the panel found this allegation was supported by Witness 1's written statement, the Kent County Council Inspection report, and the Service Improvement Plan.

The panel determined that Witness 1 was a credible and reliable witness. The panel found that Witness 1's oral evidence has been consistent with her written evidence and that she relied on the observations she made when reviewing care plans with Person 1. The panel concluded that Witness 1's evidence was also supported by the Kent County Council's Inspection report and the Improvement Plan.

Taking account of all the information before it, the panel determined that there is sufficient evidence before it to conclude that, on the balance of probabilities, you did not ensure that in relation to Resident O, the care plan reflected the occupational therapy recommendation and how their skin integrity should be managed. The panel therefore finds this charge proved in its entirety.

Charge 17a (Schedule Q (5))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

5		Did not ensure that one, or more, resident's daily notes were reflective of the choices offered to them and/or showed how each resident's day looked on any given day

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report of May 2019, the Kent

County Council's Service Improvement Plan for the Home dated 30 May 2019 and Witness 1's evidence. The panel also took into account your evidence.
Witness 1 in her witness statement stated:

> *'Finally on review of the daily records for residents, it was noted that in general, the daily notes were not reflective of the choices offered to residents, and they did not provide enough details to show how each residents' day looked on any given day.'*

This was further supported in the KCC inspection report of May 2019 which stated:

> *'Each resident have daily notes.*[sic] *These notes need to reflect where residents are being offered choices.'*

The panel noted that the KCC inspection report would have been produced closer to the time of the visit to the Home. The panel were not provided with any specific examples of daily notes to support this charge.

The panel were referred to the action plan, but were not assisted by it, as the action plan referred to future courses of action you were expected to take. The action plan did not reference what you had been doing in respect of the daily notes.

In her oral evidence, Witness 1 explained to the panel what she would have expected you to do as a registered manager. She said,

> *'…in this home, Mrs Persand took responsibility for the support plans and the risk assessments, and I believe the staff were responsible for the Daily Care notes. But we would absolutely expect the home manager to have oversight of those care notes. And to have an audit trail so that some could be looked at to ensure that the quality was sufficient. You know, generally have oversight of what staff were recording, that kind of thing.'*

When you were questioned about the allegation you disagreed. You said:

‘Q. So what's your response in relation to the allegation that you didn't ensure that their daily notes reflected their choices?
A. I don't agree with it because we try our best. Maybe we could have add more to it. But I think we were doing enough. The carers, the nurses were doing enough. Because bearing in mind they're quite busy. It seems quite demanding job. And we always have communication training. So it's very important, clear communication to put in place. But, you know, as I say, we feel that we were doing the right documentation, but maybe we could have put more in place.’

The panel considered the information before it and noted that the NMC did not provide evidence that you had a duty to ensure that the daily care notes were reflective of the residents’ choices. The evidence relied upon was that of Witness 1 who made an assertion of what she would have expected but there was no specific evidence in the service agreement that this was a requirement. You denied the allegations and said that choices were documented in the daily care notes.

The panel concluded that there was not enough information to support the charge and that the NMC had not discharged its burden of proof. This charge is found not proved

Charge 17a (Schedule Q (6))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

6	J	Did not ensure that appropriate actions/responses were undertaken and/or recorded in relation to Resident J, who had slipped off of their chair 4 times between September and December 2018

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report of May 2019, the Kent County Council's Service Improvement Plan for the Home dated 30 May 2019 and Witness 1's evidence. The panel also took into account your evidence.

The panel noted that this charge relates to your actions/responses to the incidents alleged.

Witness 1 in her oral evidence and in her witness statement stated that she had reviewed some incidents, where it was recorded as to what action should be taken but there was no record as to whether these actions had been carried out. Witness 1 further stated:

> *'It was also noted that where a resident had a number similar incidents* [sic]*, there was no record of what actions were being taken to review the incidents or of steps taken to reduce the risk of the similar incident reoccurring. For example, Service User J had slipped off her chair four times between September and December 2018. However, there was no evidence of what action had been taken to investigate why this was happening. Therefore, our concern was that the Home could not demonstrate whether the appropriate actions/response had been taken, such as a referral to occupation therapy and other actions taken to prevent these incidents from reoccurring'*

This was further confirmed in the KCC inspection report from May 2019:

> *'Incident and Accident Reporting:*
> *The home has an accident book for recording accident and incidents and the Home Manager then has a file to oversee the incidents.*
> *The overall view of incidents looks at what action should be taken but not whether it has actually happened. For example, a resident slipped off a chair, the action said to replace the chair but didn't confirm whether this had actually happened.*

One resident slipped off her chair 4 times between September and December and there was no evidence of what action had been taken to investigate, refer to OT or how to prevent this from happening again.

…

There needs to be reference to when a resident has a number of similar incidents in a row what action has been taken to review these incidents and steps taken to reduce the chances of a similar incident re-occurring.'

The panel found Witness 1 to be consistent in her evidence. Witness 1 was clear that there were records that she reviewed. However, there was no record of the follow up action that should have been taken.

In your oral evidence, you denied the allegations and said you could not remember the specific details about this incident and that you did not have the incident or accident book before you.

When questioned, you said the following:

'Q. If a service user had fallen off a chair four times, would you expect it to be recorded that action had been taken?

A. Yes, it will be in an incident and accident book and what action should be taken and this will be documented in her notes and in her folder, there is a care plan for falls. So this will be documented in the falls care plan.'

Taking everything into consideration, the panel determined that, based on Witness 1's evidence and the KCC inspection report, that it is more likely than not you did not ensure that appropriate actions/responses were undertaken and/or recorded in relation to Resident J, who had slipped off their chair 4 times between September and December 2018.

This charge is found proved.

Charge 17a (Schedule Q (7))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

7		Did not ensure that one, or more accident/incidents were accurately/appropriately recorded

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report of May 2019, the Kent County Council's Service Improvement Plan for the Home dated 30 May 2019 and Witness 1's evidence. The panel also took into account your evidence.

This charge refers to the actual recording of accident/incidents.

The panel considered that Witness 1 in her witness statement stated:

'There was an accident book in place for recording accidents/incidents, and it was noted that the Registrant had a file in place to oversee incidents which had been occurring. I do not have a copy of this.'

This was consistent with what was stated in the KCC inspection report from May 2019 which confirmed the same information. There was no further information as to what accidents or incidents were not accurately or appropriately recorded.

You denied the allegations.

The panel noted that the evidence as presented by the NMC was that there was an accident/ incident reporting book but there was no such evidence that assisted with the charge in respect of accidents/ incidents that were not accurately or appropriately recorded. Therefore, the panel determined that this charge is found not proved.

Charge 17a (Schedule Q (8))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

8		Did not ensure that the Deprivation of Liberty ('DoLS') tracker was kept up to date

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report of May 2019, the Kent County Council's Service Improvement Plan for the Home dated 30 May 2019 and Witness 1's evidence. The panel also took into account your evidence.

This charge relates to the DoLs tracker and not to the DoLs documentation of residents at the Home.

Witness 1 in her statement stated:

'…the DoLs tracker which was in place needed to be updated to ensure that the dates were correct and deceased residents had been removed. To explain, the DoLs tracker is a record of all of the residents in the Home with a DoLs in place and the date that they expire to help ensure that the Home is re-applying for the DoLs appropriately etc.'

The KCC inspection report from May 2019 stated:

'There is a DoLs tracker in place but it needs to be updated to ensure dates are correct and deceased people are removed.'

The action plan was very generic in what future action needed to be taken concerning DoLs. It did not specify how the DoLs tracker is to be updated or why this has to be done.

In your oral evidence you told the panel that Registered Nurse 2 was responsible for updating the DoLs tracker and that you would audit this. When questioned about the DoLs tracker you said:

> *'Well, what we do is it's similar to what I can recall. The name was still there, it says "deceased", it doesn't mean we only put -- the client has passed away. We didn't remove the name physically, but there's no harm in that, to keep someone's name on it. It clearly says, "passed away", "deceased already" but we didn't physically remove the name from the list.'*

The panel also considered that the KCC contract did not indicate that the DoLs tracker needed to be completed or kept up to date, or that the names of the 'deceased' residents had to be removed from the tracker. The panel determined that on the balance of probabilities updating the tracker to mark residents as deceased rather than removing them, was keeping the tracker updated and therefore you did ensure the appropriate standard of care was provided.

This charge is found not proved.

Charge 17a (Schedule Q (9))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

9		Did not ensure that one, or more, residents had their own room and/or the reasons for any residents who shared a room were recorded

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report of May 2019, the Kent County Council's Service Improvement Plan for the Home dated 30 May 2019, Kent County Council Service Specification Document and Witness 1's evidence. The panel also took into account your evidence.

Witness 1 in her statement stated:

> *'It was noted that there were two rooms located on the upper level of the Home that were being shared by two residents each. All four residents were KCC funded residents. Page 6 of the contract specification between KCC and the Home (Exhibit SC/02) states "the Service shall comprise of a single room (unless residents have expressly wished to share a room… ".'*

The panel also had sight of the KCC service specification document which confirmed the contract specification between KCC and the Home.

Witness 1 also mentioned that this was discussed with you at the time. The panel noted that Witness 1's evidence was consistent with the KCC inspection report which identified:

> *'The Home Manager has said that it is the individual's choice to share however this is not evidenced anywhere. The Home Manager says that three of the residents have capacity and one doesn't there should also be a best interest decision on file. It is important to document that residents themselves and where appropriate family members and professionals have been involved in making this decision and that is evidenced. If the Home cannot evidence that this is the individual's preference they will need to be moved to their own rooms.'*

The action plan detailed future action relating to the concerns raised about the room sharing.

You accepted that some residents shared rooms, but you said that some of the residents had capacity and made their choice to share. The panel found that you were evasive in your answers to the questions regarding the shared rooms.

You were asked:

> *'Q. What I'm asking is do you accept that it should have been recorded somewhere, as in written down why a patient was in a shared room?*
> *A. So when they come to us, ten years ago, they would have asked the question, so then it would have been documented. But these folders, these files, these care plans had been changed over and over by KCC or CQC. Different people come in, so I don't know. Maybe these didn't enter in, I don't know the answer to that. But the choice was to the client, they chose the room. So when they joined the nursing home, at that time, this would have been recorded.'*

The panel determined that Witness 1 was consistent in her evidence regarding this charge and the KCC inspection report was produced close to the time of the inspection. When you were asked by KCC staff about residents who chose to share a room at the time of the inspection, you were unable to provide documentary evidence to support this choice. The panel therefore find this charge proved.

Charge 17a (Schedule Q (10))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
a) As set out in Schedule Q, as at the date of the inspection on 30 May 2019;

10		Did not ensure that one, or more, smoke detectors were replaced/working between 15 February 2019 and 30 May 2019

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report of May 2019, the Kent County Council's Service Improvement Plan for the Home dated 30 May 2019, Kent County Council Service Specification Document and Witness 1's evidence. The panel also took into account your evidence.

Witness 1 stated in her witness statement:

> *'The fire systems were tested on 15 February 2019 and the report reflects that two smoke detectors needed replacing. These had not been replaced at the time of the visit on 30 May 2019.'*

The KCC inspection report identified that *'2 smoke detectors'* had not been replaced. This was further mentioned in the service improvement plan as something that needed to be actioned in the future.

Witness 1 in oral evidence confirmed that she had seen the fire risk assessment that identified that two smoke detectors needed replacing and that she had asked you whether they had been replaced and you said they had not.

When questioned you said:

> *'Q. So you accept that in May 2019, it's possible that the smoke detectors had not been replaced?*
> *A. No, I don't accept that because it would only be a short -- I can't remember exactly but we wouldn't leave it a long period of time. So, the inspector, what I'm thinking is Witness 1 would take the contractor's folder because they would write what they found "Pass, pass, need changing, pass, need changing." So then they -- I can't remember exactly and then -- I don't know the answer to that, I can't remember.*
> *Q. If something was replaced, as in a smoke detector, would you expect that to be recorded somewhere, that that had been replaced?*
> *A. Oh no, when the contractor comes, they will record it themselves in the book they have replaced it'*

The panel found that you were unable to answer the question as to whether the smoke detectors had been replaced. The panel relied upon the evidence of Witness 1, who was consistent in her evidence regarding the charge.

The panel finds this charge proved.

Charge 17b (Schedule R (1))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

1		Did not ensure that one, or more, items of the Action Plan following the inspection of Kent County Council on 30 May 2019 were completed

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report 22 October 2019, the Kent County Council's (KCC) Service Improvement Plan for the Home dated 11 July 2019 and Witness 1's evidence. The panel also took into account your evidence.

Witness 1 in her statement stated:

'I carried out an inspection on 22 October 2019 with [Witness 4] *(Commissioner at KCC) and* [Ms 4] *(Trainee Commissioner at KCC). At this time, the Registrant was present in the capacity as Registered Manager. There were 12 residents in the Home and nine of them were KCC funded residents. I exhibit the inspection report at Exhibit SC/05.*

…

38. From our July 2019 action plan the only thing that had been completed was that a Deprivation of Liberty ('DoLs') tracker had been put in place, and the

remaining improvements still required action. As noted above, some improvements had been made to the care records, but overall the documentation for some residents was still not sufficient.'

The panel had sight of KCC's service improvement plan for the Home dated 11 July 2019, risk assessments and care plans remained a concern that needed to be actioned by you as the registered manager and to be completed by October 2019. The panel noted from the KCC inspection report dated 22 October 2019 the following were raised about care plans and risk assessments:

'•There is a two page care plan document which summarises a persons care need. This is a good document but in isolation does not contain enough information.
• There are more risk assessments that have been reproduced. However, the care plan and risk assessments seem to be confused.'

Further in the inspection report the following was summarised:

'We acknowledged that some improvements had been made to files since our last visit however, there were still serious concerns about the standard of support documentation and the standard of care at the home.

Commissioning cannot continue to visit every three months to improve the delivery of the contract at the home. A lot of the issues raised today and at previous visits are not new and have been ongoing for sometime and it is not able to continue.'

When you were questioned about this charge you said:

'Q.Do you accept that not all of those actions had been completed by October 2019?
A. From what I recollect is we will have a date and prior to -- and we will finish, we will complete before the next inspection or the next visit so it would have been completed. Which page again did you say this is? Sorry, it's 10 –

Q. Do you accept that in October 2019, Witness 1 still had concerns about the home?
A. Of course she will because that was her target to find faults. To find concerns.'

The panel considered the evidence before it. It noted that Witness 1 was clear and consistent in her evidence regarding the inspection visits to the Home in 2019. The panel also had sight of the improvement plan of July 2019 and was able to cross reference this with the inspection report of October 2019.

The panel acknowledged that some improvements had been made by you at the Home, but it could not ignore the *'serious concerns about the standard of support documentation and the standard of the care home'* or *'a lot of the issues raised today and at previous visits are not new and have been ongoing for sometime and it is not able to continue'.* The panel also considered your concerns that the Home was being targeted to find concerns with a view to closing the Home. However, there was no evidence to support this assertion.

The panel preferred the evidence of Witness 1, as it was able to identify that the care files and risk assessments were still not at an acceptable standard despite having worked with KCC's quality improvement team. Therefore, this charge is found proved.

Charge 17b (Schedule R (2))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

2		Did not ensure that one, or more, of the following environmental safety concerns were addressed:

		a) rubbish piled in the garden and/or bins at the front of the Home overflowing; b) Safe use of extension leads/electrical systems; c) Split wheelchair cushions posing an infection risk;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report 22 October 2019, the Kent County Council's (KCC) Service Improvement Plan for the Home dated 11 July 2019 and Witness 1's evidence. The panel also took into account your evidence.

The panel noted that the KCC inspection report dated 22 October 2019, highlighted the following:

'• There is a pile of rubbish that needs to be disposed of in the garden
• Bins at front of property were overflowing which poses health and safety and hygiene risks
• There are extension leads plugged into extension leads with hanging cables in the nurses station. When we questioned this Mrs Persand informed us that the fire brigade had had no problem when they visited. We have looked into this and it is not advised practice, it could invalidate the home's insurance so needs looking into.
…
• Wheelchair cushions had split in, these should be disposed of due to infection hazard.'

Witness 1 in her witness statement confirmed the above information and stated at the time of writing the witness statement in December 2020 that the concerns had been actioned and rectified.

When questioned by Ms Girven, you gave the following responses:

‘Q. Do you accept that in October 2019, there was rubbish in the gardens and the bin was overflowing?

A. The visit on the day, from what I can recall, the next day, the collection of bins and the rubbish in the garden, there was no rubbish in the garden but we had a skip because we were renovating the place basically. There was no rubbish in the garden, no.

Q. Do you accept that in the garden there was extension leads plugged into extension leads essentially creating a chain of extension leads?

A. We had a plug which connected -- which you can plug other appliances to it, yes.

Q. So were there extension leads plugged into extension leads?

A. No.

Q. If we look at the environment, which is the fifth bullet point down, and it states that's what Witness 1 observed. You stated the fire brigade had no issue with it.

A. Can I just say there was a plug plugged in the socket. There was a plug with multiple functions plugged in the socket, then there was -- I don’t know what was connected to that, I can't recall off the top of my head. So there are extension leads plugged into extension leads. I can't recall extension lead plugs into extension leads.

Q. Do you accept there are wheelchair cushions that had split in the home?

A. I think we had a conversation about this, the wheelchair cushion that had split that was in the communal -- that was put at the back. So thinking about it, it was a cushion put at the back to be discarded.

Q. So you accept that it was still within the home and had not yet been discarded?

A. Yes, it was inside. I mean if I put it outside, what else would we have instead? There was a pile of rubbish in the garden, but it was inside, ready to be discarded, put on the side to be taken out.

Q. How would someone know that that cushion was not to be used? Was there a sign on it saying, "Do not use?" or –

A. Each individual had their own wheelchair so this one didn’t -- it hadn't been used by anyone. If she did ask, we would have told her that these are to be

thrown away because we had wheelchair checks and some of the wheelchairs needed to be replaced.'

The panel considered the evidence before it. It noted that the inspection report from October 2019 was completed by Witness 1, who in her evidence confirmed she had observed the concerns raised. The panel found that Witness 1 was consistent with her evidence and the documentary evidence was contemporaneous as the inspection had occurred in October 2019. The panel also considered that when you were asked questions, your answers were not consistent and at times were confusing as to whether you accepted what was being said to you.

The panel concluded that on the balance of probabilities you had not ensured that one or more of the environmental safety concerns had been addressed. The panel finds this charge proved.

Charge 17b (Schedule R (3))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

3		Did not ensure that one, or more, of the following health and safety concerns were addressed: a) Fire door being propped open with objects and furniture; b) The condition of the shower room;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report 22 October 2019, the

Kent County Council's (KCC) Service Improvement Plan for the Home dated 11 July 2019 and Witness 1's evidence. The panel also took into account your evidence.

The panel noted that Witness 1 in her oral evidence confirmed that she had seen the fire door propped open with objects and furniture. This was confirmed in the October 2019 inspection report and also in Witness 1's witness statement.

Witness 1 in her witness statement referred to the concern around the condition of the shower room:

> *'At the time of the visit, occupational therapy had raised a concern with the shower room (which was the only one currently available for use by residents). The concerns raised were:*
> *a. It was a shower cubical* [sic] *and not a level access shower;*
> *b. There was a lack of circulation space and therefore a lot of manoeuvring was required to turn commode chairs into the shower;*
> *c. The step into the shower had been tiled over to create a ramp effect;*
> *d. There was very limited access (to include steep and uneven access) into the shower area – this was not compliant with guidelines;*
> *e. There were concerns about the stability of the existing shower chair.'*

The inspection report dated 22 October 2019 identified these concerns.

In oral evidence, Witness 1 was asked whether she had discussed the concerns with you in respect of the shower cubicle. Witness 1 said:

> *'A. A lot with Mrs Persand, and occupational therapists had discussed it as well. The shower was, was wholly unacceptable really, for the size of the home and the needs of the residents. Yeah, it was discussed a number of times.'*

You gave the following responses regarding the above charges:

> *'Q. Did you ensure that the fire doors were always kept closed?*
> *A. Yes.*

Q. Were you aware that KCC had concerns about the condition of the shower cubicle, the shower room?

A. The shower room, they mentioned something about it, but the concern, what was the concerns because it was working fine? It was a bit tight. What concern was it because I'm not aware of any concern?

Q. If we look at page 1083, there are five different concerns about the shower room in that it was a cubicle and not a level access shower. There was a lack of space. The step had just been tiled over to create a ramp. There was limited access or steep, uneven access and the shower chair was not suitable.

A. I do admit it wasn't spacious but it was working -- it was in good, fine working condition. It wasn't spacious so there wouldn't be a lot of space to -- it was functioning. There was a slope but we had to have this for them to have water contained in there. If you had it flat, it would have run into the shower room, I mean the bathroom. So you've got to have a little bit of steepness so that the water doesn't come out into the corridor or into the bathroom. But I do agree it was small, but it was functional.

Q. Do you accept the shower wasn't specifically designed for someone with mobility issues?

A. The people going in there were going in there by wheelchair, having -- in a shower chair, sorry, in a shower chair. So, I mean it wasn't -- it wasn't beautifully designed but it was practical, it was working fine. I mean there was no issue for anyone to sit in a wheelchair, shower wheelchair, it was a chair for shower basically and they would be wheeled to there from the bathroom to the shower room and then from there, they would be wheeled back to the bathroom where they would get dressed or dried or any other activities. It wasn't a bathroom with a shower on its own, no.'

The panel considered the information before it. It had a first-hand account from Witness 1 who was the commissioner at KCC who inspected the Home on 22 October 2019. Witness 1 confirmed seeing the health and safety concerns and also brought the concerns regarding the shower room to your attention. The panel found that Witness 1's report and witness statement was consistent, and she was able to answer questions clearly.

The panel also considered your evidence, it noted that you accepted that the shower room was *'small',* but you asserted that it was functional and practical.

Taking everything into consideration the panel determined that based on the evidence before it, you did not ensure that one or more of the health and safety concerns were addressed. This charge is found proved.

Charge 17b (Schedule R (4 and 5))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

4	D	Did not ensure that the resident's care file(s) were complete and/or accurate and/or consistent
5	K	Did not ensure that the resident's care file(s) were complete and/or accurate and/or consistent

These charges are found NOT proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report 22 October 2019, the Kent County Council's (KCC) Service Improvement Plan for the Home dated 11 July 2019 and Witness 1's evidence. The panel also took into account your evidence.

The panel decided to consider sub charges 4 and 5 together as it related to the same information being considered for both service users.

The panel had sight of the KCC inspection report dated 22 October 2019. It noted the following:

‘We reviewed two files (SU:D and SU:K) and the further improvements we identified:

• Throughout the files there are spelling errors and inconsistent information. For example, a choking assessment was referred to a ‘shocking’ assessment. A residents file referred to a catheter being emptied when ¼ full, we were informed this was incorrect and should be ¾ full. A residents religion was referred to as ‘xtrian’ and roman catholic. It was not clear what religion he actually followed.’

Witness 1 in her statement confirmed the following:

‘*There were spelling errors throughout the files and inconsistent information in the files;’*

The panel noted that it did not have sight of the care files that were seen in the October 2019 inspection. Further the panel was not provided with an example of *‘inconsistent information’*.

It was the NMC’s case that this charge related to spelling errors.

You gave the following responses:

‘Q. Do you accept there were spelling errors within care plans?

A. No.

Q. Did you check care plans yourself to make sure spelling and information was accurate?

A. There was some -- I think there was a typing -- when you're typing, there was a typing error in there, there was. It's not that people can't read or people don’t know how to pronounce the word, it was a typing error. Sometimes, when you put a word in, a different word with come in or tap in.

Q. Do you accept it was important for care plans to be accurate and that any errors are picked up and corrected?

A. Yes, they should be picked up and corrected definitely, but still it doesn't -- I mean there was, I remember there was something, but still, people could read

it. It didn't affect the care plan, there was -- there was a mistake, a pure mistake of typing.'

The panel considered all the evidence before it. It noted that these charges related to '*Did not ensure that the resident's care file(s) were complete and/or accurate and/or consistent'.* The panel was not provided with what information was necessary to be recorded in the resident's care files to be accurate and consistent. Ms Girven clarified on behalf of the NMC that this concerned spelling errors in care files. The panel did not consider this to be sufficiently serious to say that you did not ensure an appropriate standard of care.

The panel determined that the NMC had not discharged its burden of proof. The charges in respect of residents D and K are found not proved.

Charge 17b (Schedule R (6))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

6	K	Did not ensure that one, or more, of the daily care notes contained appropriate detail and/or was legible, including: a) Resident K

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report relating to their inspection visit on 22 October 2019 and Witness 1's evidence. The panel also took into account your evidence.

Witness 1 in this inspection report identified the following:

> *'Daily notes contained lack of detail and specifics required such as times changed etc*
> • *Daily notes ineligible* [sic] *in places*
> • *SU:K – care plan refers to he needs to be checked every 1-2 due to being bed bound yet only 2 entries on the daily notes per day'.*

Witness 1 confirmed in her statement:

> *'Further, we reviewed some of the daily care notes and noted that these contained a lack of detail and that they were illegible in places. For example, Service User K's care plan refers to the fact that he needed to be checked every one to two hours due to being bed bound, but the daily records only reflected two entries per day. We would expect an entry on each occasion that Service User K was checked at minimum stating the time that he was checked. Ideally each entry should also contain details of how Service User K was doing at each check. Service User K's care plan also referred to the resident being supported to use a commode for bowel movements, but there was no evidence of this support being provided in the daily records'.*

Witness 1 in her oral evidence confirmed that she had raised these concerns regarding the record keeping with you.

You were also asked about the daily care notes and legibility. You said:

> *'A. When I did my quality control check, they were legible and if I did pick it up, I would have recorded it in there. The nurses or carers would have been informed.'*

The panel noted that the daily care notes that would have been seen during the inspection in October 2019 were not exhibited in evidence. However, the panel noted that Witness 1 was consistent in her evidence and confirmed that she was present at

the inspection on 22 October 2019 and had reviewed these files. The panel also considered your answer regarding the legibility of the daily care notes.

The panel was mindful that the evidence it had supported the allegation that you did not ensure that the daily care notes contained the appropriate detail. However, it was not apparent what evidence the NMC was relying upon regarding the legibility of the daily care notes as the panel did not have sight of these.

In light of the evidence before it, the panel find this charge proved on the basis that you did not ensure that one, or more, of the daily care notes contained appropriate detail.

Charge 17b (Schedule R (7))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

7	D	Did not ensure that appropriate care was provided to one, or more residents including: a) Resident D in relation to supervision whilst eating; b) 5 additional residents who were observed unsupervised during lunch

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report relating to their inspection visit on 22 October 2019 and Witness 1's evidence. The panel also took into account your evidence.

Witness 1 in her statement and in evidence stated:

‘On review of Service User D's file, it was documented that he [sic] *should be supervised at all times when eating. However, we observed Service User D eating lunch and she was unsupervised for the whole meal.*
During lunch, we observed five residents in the dining room unattended and observed that they had no interaction during their lunch. We also observed that for long periods of time there was no staff members present in the lounge to keep an eye on the residents. We would expect that the residents would be supervised while eating as many residents are high risk of choking. In addition, during this lunch, one resident spilt their drink and it went everywhere, including on the floor, which created a slipping risk. There was no staff to address this and we had to intervene and go and get a staff member to assist the residents.’

In the inspection report, the same concerns were mentioned:

‘• SU:D file clearly states that she should supervised at all times to eat. When we observed lunch she remained unsupervised for the whole meal.
• 5 residents sat at the dining room unattended with no interaction during lunch’.

The panel found that Witness 1 was consistent in her evidence.

When Witness 1 was questioned on whether the concerns were raised to you, Witness 1 responded:

‘Q. … you mentioned some concerns when observing a lunch. Can you remember if Mrs Persand was present at the home during that time?

A. Yes, she was. Yeah.

Q. Do you remember where she was?

A. I think she was in her office.

Q. Did you raise the concerns you identify in that paragraph with the registrant? A. Yes.

Q. Can you remember what her response was?

A. So there was a lot of concerns around the management of choking risks at this home. Because the care and support plans weren't -- we didn't feel they were accurate in terms of people's swallowing needs. So the fact that we knew there was a number of those residents that needed to be observed and they weren't, we did discuss that with her. I wouldn't have said the response was -- I'm, I'm not sure whether Mrs Persand understood the severity of the situation. There, there wasn't really a response, really. We discussed it and we discussed that it wasn't what we would expect.'

In response to this charge, you said:

'Q. If a service user had issues with swallowing and, for example, was at risk of choking, do you accept that [sic] *should be supervised or there should have been someone near them at the time?*

A. If somebody has been assessed as having a risk of choking, so then the SALT team will advise what sort of meal they should be having, either puree. Once they are on the puree diet, they should be fine to eat their dinner on their own unless we had to feed them because they can't feed themselves.'

The panel considered the evidence before it. It found that Witness 1 to be consistent and clear in her answers on what she had observed. When you were questioned, the panel noted that you were evasive and did not answer the questions directly.

The panel determined that on the balance of probabilities, it is more likely than not that you did not ensure that appropriate care was provided to one, or more residents including Resident D in relation to supervision whilst eating, and 5 additional residents who were observed to have been unsupervised during lunch. This charge is found proved in its entirety.

Charge 17b (Schedule R (8))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:

b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

8		Did not ensure that a new carer spoke to a resident who was unsettled in an appropriate way on 22 October 2019

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report relating to their inspection visit on 22 October 2019 and Witness 1's evidence. The panel also took into account your evidence.

The panel noted that the evidence for this charge came from Witness 1's observation of the incident during the inspection in October 2019.

The inspection report stated:

> *'A new carer was observed, at times his interactions were warm and encouraging however during times a particular resident was unsettled and requiring a lot of attention and the comments made were inappropriate, personal care was referred to in an disrespectful manner and the resident was spoken to in a condescending manner.'*

Witness 1 confirmed the same information in her witness statement dated December 2020.

When you cross-examined Witness 1, she stated that she spoke to you in the office regarding the incident with the new carer, in which Witness 1 said she had observed a number of things this member of staff did. Witness 1 said:

> *'But one of the most concerning was the way that he managed this resident. And obviously the thing that he said to him, and I came and spoke to you afterwards in the office about it.'*

When questioned by Ms Girven, you said that you could not recall Witness 1 speaking to you about this concern and on some occasions during your evidence you said that you were not aware of the concern. The panel noted that your answers varied about what you recalled of the incident and that you denied the incident being reported to you.

The panel considered the evidence before it and noted that Witness 1 was a consistent witness who recalled telling you about the incident and that you were in the office. However, there was no evidence presented that you had witnessed this incident, only that you were informed of it after the event. Although the panel found that the interaction between this carer and the resident to have been deplorable, you could not reasonably be expected to ensure a carer spoke to a resident in an appropriate way, during a specific interaction you had not witnessed. The panel therefore finds this charge not proved.

Charge 17b (Schedule R (9))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
    b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

9		Did not ensure that appropriate/suitable activities were available for the residents at the Home

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report relating to their inspection visit on 22 October 2019, Kent County Council Service Specification Document and Witness 1's evidence. The panel also took into account your evidence.

Witness 1 in her statement highlighted the service agreement and what was expected of the Home to provide to its residents. Witness 1 stated:

> *'We found that meaningful interaction and activities were seriously lacking in the Home. We were at the Home from 10:00am – 5:15pm and during this time, we witnessed 10 minutes of chair exercises with some of the residents and then about 15 minutes of some ball activities. Page 14 of the specification of the contract between KCC and the Home (Exhibit SC/02) states that 'The Service Provider shall support and/or escort and/or facilitate access to social, vocational and recreational activities, both on and off-site, in accordance with the individual care needs of Residents.*'

Witness 1 in her oral evidence gave a detailed explanation as to what was expected from the Home when providing activities, there was also an expectation that the activities undertaken should have been recorded in the residents' daily notes. She stated:

> *'A. So we'd expect a range of activities really in terms of, we'd expect an activity schedule for the majority of residents. And then we would expect some more personalised. So if you have bedbound residents, obviously they're not going to be able to join in with wider activities. But I mean, different -- it's very much up to the home. But we would just ask for a, a wide variety of activities. We'd expect there to be evidence that residents were being spoken to around what kind of activities they would like. Then we would expect an activity schedule in place with a range of different things'*

Witness 1 said that she spoke to you regarding the concerns around the activities. She stated:

‘Again, it was very, it felt like we were on quite different pages around what was expected and our understanding of a residential service and what we would expect.’

When questioned about the concerns relating to the activities. The panel found that you did not answer the question directly and at times provided information that did not necessarily relate to the charge. You said the following:

‘Q. Was the activities coordinator position ever a full-time role?
A. Yes, but we never had any activities from 9.00 in the morning or until 9.00 in the evening. We've never had that. As I said, it is in regard to the client's requirement. This is a nursing home so in the morning it's always difficult for the client to engage in activities when they're supposed to. They need a wash, dress, having their breakfast. So normally, from what I can recall would be after lunch. And in the morning the staff will be given -- after their coffee, so the staff will be taking the role. I can't remember. I'm very sorry. I think there was at some point there was one of the ladies, she came in the morning just to do a few hours for …
Q. Did you have a system to ensure that there were activities if there wasn't an activities coordinator on duty? Or did you just rely on the activities coordinator?
A. No, the staff would be able to do some activities at the same time.
…
Q. … How did you as the registered manager –
A. Activities. Activities, I'm ready to say to sorry to you. Activities can be any form. Holding somebody's hand is part of an activity. Talking to someone, reminiscence with someone is part of an activity with someone in the home.’

You further stated:

‘Q. What policies did the home have in place to ensure every service user was able to engage in activities?
A. The policy? It's their choice. The activities are provided. Some decide to do something different, some decide, it's there, we don’t have any policy saying that all of them should get involved with this activity that is in place. So the activities are done individually. It's their choice which one they want to do.

If they want to play a ball game, they play a ball game. If they want to go outside for fresh air, they have a walk outside for fresh air. If they want to join the bingo, they join the bingo, they have a choice.'

You confirmed to the panel that a system was in place regarding the activities. Taking everything into consideration, the panel found that Witness 1 was credible and consistent in her evidence regarding the concern raised about activities. She gave a first-hand account of what she had witnessed, and this was stated in the inspection report. This was further supported in her witness statement. The panel also considered your evidence, where you confirmed you had a system, but you were unable to elaborate further on what activities were in place at the time. You asserted that activities are done individually and that it is a resident's choice.

The panel determined that you did not ensure that appropriate or suitable activities were available for the residents at the Home, in line with the terms of the contract commissioned by Kent County Council. This charge is found proved.

Charge 17b (Schedule R (10))

17) Failed to ensure that you/the Home provided an appropriate standard of care and/or complied with one, or more, terms of a contract commission by Kent County Council:
b) As set out in Schedule R, as at the date of the inspection on 22 October 2019;

10		Did not ensure that appropriate steps to meet the dietary needs of one, or more, residents

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included the Kent County Council Inspection Report relating to their inspection visit on 22 October 2019 and Witness 1's evidence. The panel also took into account your evidence.

The panel considered the inspection report, in which Witness 1 identified many issues with the food. The inspection report stated:

> *'When we viewed the kitchen we looked in fridges and around the kitchen. Some apples were found in the kitchen along with some parsnips, Mrs Persand informed us that there was further fruit in the fridge in the basement however when we looked we were unable to find it.*
>
> *Mrs Persand informed us that she was due a food delivery today and that more fruit and vegetables would be ordered. We were therefore unable to evidence that fresh fruit is available.*
>
> *Whilst in the kitchen it was noted that some food in the fridge was not named or dated. Milk cartons did not have labels on so we were unable to see what date the milk should be used by. There is no evidence of snack foods being available such as a range of biscuits of crisps*.'

Witness 1 confirmed she had spoken to a resident at the time of the inspection, who stated:

> *'He said he is not offered a choice of food, he says he loves fish which his nephew will bring in to him. We asked if he had access to fresh fruit and vegetables he said no.'*

Witness 1 in her statement confirmed the concerns raised in the inspection report. Witness 1 also stated:

> *'It was also noted that there were several covered plates of food served on the side ready for the evening meal. It was noted that this was the same meal as that served for lunch, which was chicken casserole, mash and carrots. The food register stated that the residents were due to have pizza for their evening meal, but based on our observations, this was not the case.'*

In her evidence, Witness 1 recalled that you did not agree with the concerns raised and that you felt the food was sufficient. Witness 1 said:

> *'I think the difficulty is from an auditing perspective, if something's not written down, we have to assume it's not happening unless the provider can evidence otherwise. But I do remember with food, she was quite adamant that that was not the case. We just weren't able to evidence any differently.'*

You told the panel that you disagreed with the concerns raised. You said that the milk would have been labelled but that you could not recall. Further, you said that you checked that the kitchen staff were ensuring food were labelled by going into the kitchen yourself and that you would have noticed the milk labelled when making coffee.

In respect of the allegation of food being covered, you said:

> *'Q. Were you aware that the kitchen would cover plates of food and cover the same thing for tea as they did dinner, as they did lunch?*
> *A. They have a different menu for supper than what they had for lunch, so I can't answer that. The meal won't be the same so I don't know.*
>
> *Q. Did you monitor what was being given to the residents for different meals?*
>
> *A. Yes, because I'd be doing supper in the evening if I'm working, I will be -- all meals, if I'm on duty, I would come out and help because this is the time when we all had it together so I would notice together with the registered nurse and the other carers.'*

Taking everything into consideration, the panel found that Witness 1 was consistent in her evidence. She was able to explain what she had witnessed and your responses to her at the time the concerns were raised.

The panel considered your evidence. You denied the concerns raised and were adamant that the provision of food was sufficient for the residents. It noted that your

answers varied in response to the questions and were sometimes not consistent in your recollection of events.

The panel therefore concluded that on the balance of probabilities, it is more likely than not, you failed to provide the appropriate standard of care when you had not ensured that appropriate steps to meet the dietary needs of one, or more, residents in line with the terms of the contract commissioned by Kent County Council. This charge is found proved.

Charge 17c

17) Failed to ensure that you/the Home notified the CQC of notifiable incidents and/or complied with regulations 18 of the Care Quality Commission (Registration) Regulations 2009
    c) Generally;

This charge is found NOT proved.

When considering this charge, the NMC were unable to adequately explain what was meant by the term *'generally'*. The panel determined that this charge was vague and lacked specificity. In addition, the evidence upon which the NMC were relying contain elements of multiple hearsay and was not tested. The panel therefore could not attribute weight to it. The panel determined that the NMC failed to discharge the burden of proving this charge.

Furthermore, as the Registrant, you are entitled to know what the NMC's case is against you. To ensure the fairness of the proceedings you should be fully aware of and understand the charges that you are facing. The panel found that, in this instance, this was not the case.

The panel noted that the evidence matrix was provided by the NMC on day six of the hearing after the majority of the NMC witnesses had given evidence. This evidence matrix identified the evidence relied upon by the NMC to support this charge. The evidence relied upon included numerous reports whose authors were not known or

available to give evidence at the hearing. You were therefore not able to ask questions of the witnesses regarding the specifics of this charge. The panel found that this was unfair to you and was not in the interests of justice.

Charge 19a)

19) Having left the Home without qualified nursing cover/staffing on 6 October 2019 as referred to in charge 18 above, you:

a) On, or around, 6 October 2019, inappropriately asked HCA 1 if you could record on SystmOne that HCA 1 had returned Patient A;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5 and Witness 6 (HCA 1 as per the charge), your evidence and local statement.

The panel considered Witness 6 (HCA 1)'s witness statement at paragraph 7,

> *'The Registrant was then going to document the incident in Patient A's electronic notes on SystemOne. When she was doing this, the Registrant asked me if she could record that it had been me who returned Patient A to the Unit. When she asked me this, I paused and thought about what the Registrant had just said, in the same way you would when someone asks you a strange question. Before I had the opportunity to reply her, she said something to the effect of "oh I won't do it like that, I'll just write that staff brought her back to the Unit". I did not say anything to the Registrant at this time, I just left it.'*

The panel found that Witness 6 (HCA 1)'s account in her witness statement was consistent with her local statement on 18 October 2019 and also when she gave evidence before the panel. Witness 6 (HCA 1)'s oral evidence was:

‘A. Well, the three of us did not really have a conversation together because initially it was just the two of us, me and the other healthcare assistant. So, when the nurse came in… and apparently she had brought the patient from Co-op. It was almost handover, so she just quickly sat down to write the report. So, that was when she -- when she was going to write the report, and then she said "Oh, can I write that it's you?" Then she just quickly said about that "No, no, I'll just write that it was staff who brought her back, without mentioning a name". So, that's what -- to the best of my remembering … that's how I recollect it.’

The panel also noted that Witness 6 (HCA 1) had a meeting with Witness 5, who confirmed that the same account was given regarding the incident.

Witness 5 in his witness statement stated:

‘[Witness 6 (HCA 1)] *explained that the Registrant then wanted to record the incident on the electronic records system. The Registrant told* [Witness 6 (HCA 1)] *that she shouldn’t have left the Unit, and as a result asked* [Witness 6 (HCA 1)] *if she could record it was her* [Witness 6 (HCA 1)] *that returned Patient A from the shop.* [Witness 6 (HCA 1)] *reported to me that she deliberated this and eventually the Registrant said that she would just write ‘staff returned’ Patient A to the Unit’.*

In Witness 5’s witness statement he confirmed that he asked you to make a statement of the events and submit this to him by 17 October 2019. He confirmed that he received your statement on 18 October 2019. The panel noted that your local statement was dated ‘*18/10/2000’,* Witness 6 (HCA 1) confirmed that this was a mistake and that your statement was provided on 18 October 2019.

During your evidence, you denied speaking to Witness 6 (HCA 1) in relation to the incidents you said,

‘Q. When you got back to the home and recorded what happened, you asked Witness 6 [HCA 1] *if you could write that it was her that retrieved Patient A, didn’t you? A. No.*
Q. But then you changed your mind and just wrote, "Staff". A. No, I didn’t have any conversation with her in that respect. There was three people in the office, me, [Ms 3] *and Witness 6* [HCA 1]*. Why would I ask Witness 6* [HCA 1]*? No, I didn’t ask anyone.’*

However, in your local statement to Witness 5 you stated,

‘11. Both members of staff [Witness 6 (HCA 1)] *and* [Ms 3] *said “I do not mind saying that is was me that brought her back to the unit”*[sic]*. I looked at* [Witness 6 (HCA 1)] *and asked if that was ok.? She said that it was no problem at all.*
12. I documented on system one records that she was brought back by one of the staff members.’

The panel found that you were inconsistent in your evidence when recollecting the events. The panel determined that Witness 5 and Witness 6 (HCA 1) were consistent in their evidence regarding the events. Witness 6 (HCA 1) said that she felt uncomfortable and was upset by your request.

Taking everything into consideration the panel determined that it was more likely than not that, on or around 6 October 2019, you inappropriately asked HCA 1 if you could record on SystmOne that HCA 1 had returned Patient A.

The panel finds this charge proved.

Charge 19b)

19) Having left the Home without qualified nursing cover/staffing on 6 October 2019 as referred to in charge 18 above, you:

b) On, or around, 6 October 2019, inaccurately recorded/wrote that staff had returned Patient A;

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's and Witness 6 (HCA 1)'s written and oral evidence, Patient A's care notes dated 6 October 2019, Patient A's Datix form, and your evidence.

The panel bore in mind its findings at charges 19a and preferred the account of Witness 6 (HCA 1) and what she said in her local statement, regarding your conversation that led to you ultimately entering the word *'staff'* in Patient A's notes. It also considered Witness 5's and Witness 6 (HCA 1)'s oral evidence.

You accepted that you wrote *'staff'* had returned Patient A, however your explanation in your oral evidence was that '*Q. when you made a record of the incident, you just wrote that, "Staff had returned Patient A" is that correct? A. Yes, and I am a member of staff, yes.'* The panel found that your recollection of events was inconsistent between what you stated in your local statement and your evidence in the hearing.

The panel also considered Witness 5's evidence, in which he said that in hindsight he would have expected the initials of the staff member rather than just the word *'staff'* to be entered in the Datix. Although he said there was no formal training on how to complete a Datix and who should be named. He approved your entry on Datix and never questioned it. When questioned by Ms Girven he said:

> *'Q. If another staff member had been involved in terms of being the person who went to go and get the patient, would you expect their name to be entered there?*
> *A. Possibly, yes. But it depends who's completing it, because sometimes. I haven't known of formal training for completing Datixes and who should be involved and who shouldn't be, and who should be named within it.*
> *Q. Okay, so the practice wasn't uniform*

A. No, so it could be up to whoever has completed it who they were going to include in it.

Q. Just below, you've got your name saying it was finally approved, and that was on the 22nd.

A. Yeah.

Q. Does that mean that you were, at that time, approved of the account given?

A. Yes, at that time I had no concerns about -- I can't really recall. As I say, you know, there's so many Datixes.'

The panel noted the wording of this charge namely 'Inaccurately recorded/wrote'.

The panel determined that you did write *'staff'* on Patient A's notes and Datix forms but this was not an inaccurate recording. The NMC have not proved that you should not have written *'staff'* on the form as you are a member of staff. Therefore, this charge is proved only on the basis that you did write *'staff'* had returned Patient A.

The panel therefore finds this charge proved.

Charge 19c)

19) Having left the Home without qualified nursing cover/staffing on 6 October 2019 as referred to in charge 18 above, you:

c) On, or around, 7 October 2019, said in the presence of Manager 1 words to the effect that HCA 1 had gone to fetch Patient A;

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's evidence, Witness 5's copy of his written statement at the time of the events, a copy of the staff rota for 6 October 2019.

The panel noted that Witness 5 had written a statement which was not dated or signed as part of his local investigation. During his oral evidence he confirmed that the statement was written close to the time of the incident. Witness 5 stated:

> *'I attended Margaret Laurie House on 7th Oct at 07:00 and sat in on the morning handover from the night staff to the day staff. Staff Nurse* [1] *was handing over to* [Registrant] *and we were discussing an incident that happened on Sunday 6th Oct.* [Registrant] *reported that she was on shift the day before and one of the went out of the unit for a cigarette at approximately 19:10.* [Registrant] *noted that she was not outside on checking and so one of the support workers* [Witness 6 (HCA 1)] *went to the local shop and found her purchasing alcohol and returned the client to the unit* [PRIVATE]*.'* [sic]

The panel determined that Witness 5's witness statement, local statement and the account provided in oral evidence were consistent.

When questioned by Ms Girven, you said the following:

> '*Do you accept that at no handover, either in the evening or the next morning did you state that it was yourself that had left the home?*
> *A. I can't recall exactly, this is many years ago, but I remember saying -- I wanted to go home anyway, I had a long day and I was trying to get everything on SystmOne. I can't remember the exact words that I said but I did say, "WE brought her back to the unit", in that respect, I can't remember exactly the exact words. I didn't mention names, no. I didn't say, "I did, she did," No'* [sic]

The panel determined that you were unable to give a clear account of what was said during handover and were satisfied that what Witness 5 said in his local statement and in evidence, was more likely than not what had happened.

The panel therefore concluded that this charge is found proved.

Charge 20a)

20) Your conduct at any and/or all of charges 19(a)- (c) inclusive above was dishonest in that you:

a) Knew that you had left the Home to return Patient A;

This charge is found NOT proved.

The panel considered whether your conduct in knowing that you left the Home to return Patient A was dishonest. It had regard to the test set out in *Ivey v Genting Casinos:*

What was the defendant's actual state of knowledge or belief as to the facts;
Whether that belief was genuinely held; and
Was the conduct dishonest by the standards of ordinary, decent people?

The panel determined that you knew you had left the home unattended, however that fact in itself is not dishonest. This charge is found not proved.

Charge 20b)

20) Your conduct at any and/or all of charges 19(a)- (c) inclusive above was dishonest in that you:

b) Intended to conceal that you had left the Home;

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's and Witness 6 (HCA 1)'s evidence, your local statement and evidence.

The panel considered your conduct at the time. It determined that you did intend to conceal that you had left the Home. The panel based this on the evidence provided by Witness 6 (HCA 1), who the panel determined was consistent with her recollection of events. In your local statement you had indicated,

> '*10. Staff,* [Witness 6 (HCA 1)] *and* [Ms 3] *(Carers), praised me for my courage and strength. It was at that point that I realised that I should not have gone myself due to me being the only qualified nurse and I should not have left the unit.*
>
> *11. Both members of staff* [Witness 6 (HCA 1)] *and* [Ms 3] *said "I do not mind saying that is was me that brought her back to the unit". I looked at* [Witness 6 (HCA 1)] *and asked if that was ok.? She said that it was no problem at all.* [sic]
>
> *12. I documented on system one records that she was brought back by one of the staff members.'*

The panel considered the factors in *Ivey v Genting Casinos.* It determined that your belief at the time was that you left the unit when you knew you should not have done. In order to hide this fact, you tried to have Witness 6 (HCA 1) take responsibility. When that did not work, you then stated that it was a "staff member" who returned Patient A. The following day at handover you then stated that Witness 6 (HCA 1) had brought Patient A back. This was witnessed by Witness 5. At no point during the ensuing week did you mention that it was you who had brought back Patient A to the unit. You had another opportunity to take responsibility for returning Patient A when Witness 5 encouraged you to complete a Datix form about the incident. However, yet again you wrote that one of the staff members returned Patient A. You only acknowledged that it was you who had returned Patient A on 15 October 2019 when you spoke to Witness 5. This was more than a week after the incident.

Although you are a staff member, the panel determined that your reason for recording "staff" was to be evasive and conceal the fact that you had returned Patient A.

In these circumstances, the panel determined that, by the standards of ordinary, decent people, the conduct you displayed was dishonest. The panel, therefore, finds this charge proved.

Charge 20c)

20) Your conduct at any and/or all of charges 19(a)- (c) inclusive above was dishonest in that you:

c) Intended to create the misleading impression as to the events involving Patient A on 6 October 2019

This charge is found proved.

The panel determined that you had left the unit unattended which you knew you should not have done and that was your knowledge and belief at the time. You intended to conceal this fact by creating a misleading impression as to the events, when completing both the records and at handover the following day. The panel was of the view that ordinary, decent people would find your conduct to be dishonest.

The panel therefore find this charge proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

Ms Girven referred the panel to '*The Code: Professional standards of practice and behaviour for nurses and midwives (2015)*' (the Code). She identified the specific, relevant standards which were 1.2, 1.4, 2.2, 2.4, 3.1, 3.3, 3.4, 6.2, 8.2, 8.4, 8.5, 10.1, 10.2, 10.3, 11.1, 11.2, 11.3, 14.1, 16.1, 16.4, 20.1, 20.2, 25.1 which she submitted you were in breach of. She said your actions amounted to misconduct.

Ms Girven told the panel that she would look at the charges in two blocks, the first block would be the Abbey Court Care Home relating to the management of the care home and, the second block, regarding the dishonesty allegations.

In respect of the Abbey Court Care Home charges, Ms Girven submitted that you did not need an NMC PIN to do the role as a manager, but that this role was intrinsically linked to your nursing profession. Ms Girven submitted that the panel found failings in skills that would be expected of a registered nurse for example recordkeeping and care planning. Further, she submitted that although you were not acting as a registered nurse on all occasions, you were a registered nurse at the care home. Ms Girven submitted that those charges are intrinsically linked and satisfy the test in *Roylance* and amount to professional misconduct.

Ms Girven submitted that based on the evidence from the CQC and KCC the concerns were serious as it resulted in the care home being closed down. She

submitted that patients were put at significant risk of serious harm in particular to the failure of risk assessment in a care plan, not escalating a patient who had fallen, not appropriately managing staff members about whom there were concerns. Ms Girven submitted that, although actual harm was not caused to patients, they were put at significant risk of harm which meets the threshold for misconduct.

In respect of the dishonesty charges, Ms Girven submitted that this relates to your professional practice as you were working as a registered nurse. She submitted that your actions in this case are serious. Ms Girven submitted that the panel have found dishonesty proved and that dishonesty is always serious and falls below the standard that is expected of a registered nurse.

Ms Girven submitted that the facts found proved individually and collectively amounted to misconduct.

You told the panel that you would be relying on your statement in respect of the misconduct and impairment stage. Your written statement is as follows:

> *'Facts proven 1 a./4a./6a./7a./15a.17a./17b. are clients related from Abbey court nursing home. I worked very closely with my team and together we put our residents' best interests first. I am not saying everything was 100 % perfect in the care home but as per witness 2's statements, I am well aware of all residents' diagnosis. While CQC and social services organisations were conducting their visits my team and I never gave up. We remained dedicated to providing home -like care until the very last day of our care home's operation. From the bottom of heart I know I gave my residents the best care possible.*
>
> *During all those difficult time none of the residents experienced*
>
> 1. *Serious medication error*
> 2. *Physical abuse*
> 3. *Financial abuse*
> 4. *Psychological abuse*

5. *Sexual*
6. *fire incidents*
7. *Neglect*
8. *Exploitation*
9. *No harm or serious harm*
10. *No death due to neglect*
11. *malnutrition*
12. *Pressure sores*
13. *Falls and injuries*

I have been working in social care since 1989, approximately 36 years. I genuinely love and care of what I do. Throughout my extensive career I have consistently demonstrated my commitment to providing compassionate and trustworthy care. My colleagues and residents alike can attest to my responsible nature. I always prioritize the well-being of those I serve. I believe that building trust is essential in this field, and I have cultivated strong relationships with residents and their families, ensuring they feel safe and supported. I have never encountered any issues or difficulties in my entire career, which is reflected in the testimonies provided. I am committed to continuous improvement, regularly updating my knowledge and skills to provide the best possible care. I have enriched my expertise by completing the following courses...'

Submissions on impairment

Ms Girven 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. Ms Girven referred the panel to the NMC's guidance on impairment which states:

'*The question for the panel to consider at this stage is can the nurse practise kindly, safely and professionally?'*

Ms Girven referred the panel to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* | [2008] EWHC 581 (Admin).

In respect of the case of *Cohen,* Ms Girven invited the panel to consider three questions. Whether the conduct is easily remediable; whether it has, in fact, been remedied; and whether it is unlikely to be repeated. Ms Girven took the panel through the first limb of the test and referred the panel to the NMC's guidance FTP15(a) which sets out factors which are more difficult to address, for example dishonesty is something that is harder to be addressed, particularly if it was serious and sustained over a period of time or directly linked to the nurse's practice.

Ms Girven submitted that this was relevant as the dishonesty charge was found proved and that this goes directly to your practice. Although as a one-off incident it is still serious. Ms Girven submitted that, in respect of the management concerns, they are easier to address if appropriate insight and training is evidenced.

Ms Girven submitted that your insight is very limited and that you do not accept any of the failings in the care home and your reflective statement does not address the dishonesty allegations at all. Ms Girven invited the panel to consider the consequences of your continued denial when considering the question of insight.

Ms Girven referred the panel to the case of *Sawati v General Medical Council* [2022] EWHC 283 (Admin), which dealt with when a registrant continually denies something and whilst it did state that a registrant is, of course, entitled to raise a defence, the panel should consider the nature of that defence when considering the insight. Ms Girven submitted that you denied both the primary and secondary facts, in that you denied the fact that you asked a colleague to record something that was not true as well as also denying that this was dishonest. Ms Girven submitted that you have failed to accept any of the aspects of the dishonesty charge, and this demonstrates a lack of insight.

Ms Girven submitted that you have also shown limited insight into the concerns in your role as a registered manager of a care home. She said you instead focused on

the fact that patients were, in your view, not harmed and you have sought to explain that the CQC and KCC had ulterior motives. Ms Girven submitted that you have not shown sufficient insight, if any, at this stage.

Ms Girven acknowledged that you provided positive testimonials albeit that only one testimonial was from a colleague, and two testimonials from your patients. Ms Girven pointed out that there was no testimonial from your current line manager. Ms Girven said it is unclear from the documents what capacity you are currently working in and how long you have been working in this role.

Ms Girven highlighted to the panel that you had provided evidence of some training that you have completed, some of which is relevant to some of the care management concerns. However, Ms Girven said that no training certificates were provided or further information about the nature of the training. She said that the majority of the training undertaken seems to be mandatory training and suggests that you have not gone far enough in remediating your practice.

Ms Girven submitted that dishonesty is hard to address through training. You have not provided any evidence of training or reading that has gone into the consequences and importance of honesty in the workplace.

Ms Girven referred the panel to the four-stage test in *Grant*, which she submitted all limbs applied in your case. Ms Girven highlighted the limbs of the *Grant* test, those being whether you have, in the past, acted and/or are liable in the future as to put patient or patients at unwarranted risk of harm. Secondly, whether you have in the past brought and/or are liable in the future to bring the nursing profession into disrepute, whether you have in the past breached and/or are liable in the future to breach one of the fundamental tenets of the nursing profession and whether you have, in the past, acted dishonestly and/or are liable to act dishonestly in the future.

Ms Girven submitted that in both the care home allegations and the dishonesty allegation, you put patients at unwarranted risk of harm. This was evidenced by the level and nature of the concerns raised by the CQC and KCC. The care home service users were vulnerable. It was submitted that the failings identified, and the

charges found proved put those patients at unwarranted risk of harm throughout. In respect of Margaret Laurie House, leaving the unit without a registered nurse put the remaining patients at unwarranted risk of harm. Ms Girven said that the dishonesty does in the future demonstrate a risk of harm as it is a great concern.

Ms Girven submitted that you have in the past, brought the nursing profession into disrepute in relation to your actions and failings, both at the care home and in relation to the dishonesty allegations.

Ms Girven submitted that you had breached a fundamental tenet, in that honesty is one of the fundamental tenets of the nursing profession, but the basic skills such as record keeping and care planning were also breached.

Ms Girven submitted that the panel has found that in the past you acted dishonestly, she submitted that there remains that risk going forward.

Ms Girven invited the panel to consider that the care home allegations were spread over a significant period of time and there was repetition even when concerns were brought to your attention by the CQC and KCC, the concerns continued. This is in relation to the facts that were found proved. Ms Girven said that in relation to the action plan, you “did not ensure that one or more of items of the action plan following inspection were completed”, she submitted that there were failings before, and they were not acted upon which increases the risk of repetition.

Ms Girven submitted that due to the level and nature of the concerns, including dishonesty, public confidence would be significantly undermined, if a finding of impairment were not made. Ms Girven clarified to the panel that the Abbey Court concerns, due to their nature and breadth, the public would be extremely concerned if a finding of impairment were not made, particularly if these led to the care home having to be closed down.

Ms Girven invited the panel to find impairment on both public protection and public interest grounds.

You told the panel that you are not in denial of all the charges made against you. You explained you are facing a lot of charges and that you did not cause anyone harm.

You explained to the panel that you have been a carer since 1989 and that you only have the best interests for your residents and clients. You said that you had been a home manager for 15 years until the Home closed in 2020, you were dedicated to the role. You said that you have never had any issues or problems with anyone, and no one had referred you to the NMC until now.

You told the panel that you would address the allegations of the Home and the dishonesty.

In respect of the Home, you said that you gave your all, and that it was very sad time when the Home closed. You talked about the hard work you did together with your team including care planning, risk assessment, and the maintenance of the building. You said that you had invested a lot of money into the Home and that you fought until the last day.

You said in respect of the dishonesty allegation, that you accept having left the home to save someone's life. You expressed that you wanted to help the patient. You said that you left behind the other residents in the capable hands of someone who had been a nurse who you had worked with for many years. You then said that at the time of the incident you did not know that the other staff member was not actually a qualified nurse.

You said that you had no intention to conceal your actions. You said "I could have been more detailed by stating I had returned the patient. I was just documenting it on Datix." You said that you were not trying to be dishonest, you just wanted to pick the patient up and save their life.

You explained to the panel that it was a mistake and that you would not do it again. You said that you would take your time to document and not rush. You said that you have learnt from your mistake that it is important to record every little aspect, it would

be dishonest if not recorded properly. Further, you explained that you have learnt your lesson and that you would ask someone to read over your entry if you have missed something as confirmation before submitting the document.

You explained to the panel your current employment and your roles and responsibility. You said that the testimonials were written by the patients and signed by them. You explained that the training you had done was a combination of online training and external face to face training.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Ahmedsowida v General Medical Council* [2021] EWHC 3466 (Admin), *Schodlok v General Medical Council* [2015] EWCA Civ 769, and *CHRE v NMC and Grant.*

Decision and reasons on misconduct

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

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

*1 **Treat people as individuals and uphold their dignity***
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns
2.1 work in partnership with people to make sure you deliver care effectively

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

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

6 Always practise in line with the best available evidence

8 Work co-operatively

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.

***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*

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

11 Be accountable for your decisions to delegate tasks and duties to other people

***11.1** only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*

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

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

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

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

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

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

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

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

20 Uphold the reputation of your profession at all times

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

20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*

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

20.5 *treat people in a way that does not […] cause them upset or distress*

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It went onto consider each of the charges individually.

Charge 1a - Schedule A (8)

The panel noted that this charge related to a fire exit being blocked. It considered that, as the registered manager of the Home, you held primary responsibility for ensuring that care and treatment were delivered in a safe environment. Fire safety is a fundamental requirement in any care setting, particularly in a nursing home where many service users are elderly, frail, or have mobility issues that would impede rapid evacuation. The panel found that this conduct was in breach provisions of the Code, namely 16, 19, and 19.1 in that you failed to act without delay to mitigate a clear fire safety risk, thereby exposing residents to serious harm.

The panel appreciated that not every breach of the Code amounts to misconduct. However, the failure to identify and rectify a clear and avoidable fire safety hazard constituted a serious departure from the standards expected of a registered nurse and registered manager. Accordingly, the panel found that your actions in respect of Charge 1a Schedule A (8) fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 4a - Schedule D (3)

The panel considered that the Home was responsible for providing care to highly vulnerable service users, many of whom were living with dementia and had complex emotional and physical needs. In such settings, the provision of structured, meaningful, and individualised social activities are a core component of person-centred care and formed part of the KCC contract with the Home.

The NMC's FTP-2a guidance emphasises that failure to meet basic standards of care and responsiveness to people's needs - especially those that affect dignity and wellbeing - may constitute misconduct. The panel noted that the evidence before it showed there was a sustained lack of structured, personalised activities, particularly for more vulnerable residents, despite repeated concerns being raised to you.

Your actions as set out in this charge breached provisions 1, 1.1, 1.2, 1.4, 2, 2.1, 3, and 3.1 of the Code. The panel determined that your failures demonstrate that you

did not ensure the provision of structured, person-centred activities, which had the potential of compromising residents' dignity, emotional wellbeing, and individual care.

This was not a single failing, but part of a broader pattern of disregard for regulatory guidance and failure to provide holistic care. It reflected a lack of understanding of the importance of meaningful engagement for vulnerable residents and was contrary to the core values of the nursing profession. Accordingly, the panel found that your actions in respect of Charge 4a fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 6a - Schedule F (6)

The panel considered that as the registered manager, you had direct and overall responsibility for safeguarding residents and responding to concerns about staff conduct. Staff Member 1 had a live caution recorded on her NMC registration and had been the subject of a further allegation. Despite these known risks, you permitted her to work unsupervised as the lead nurse on shift and without any risk assessments being carried out.

The panel accepted Witness 1’s evidence that no meaningful safeguarding measures were in place. Although you claimed supervision occurred, you provided no records to support this, and the panel was not satisfied that appropriate steps had been taken. The panel concluded that this conduct represented a significant failure in professional judgement and leadership.

The NMC’s FTP-2a guidance is clear that failures in safeguarding - particularly where residents are placed at risk from staff under investigation - can amount to serious professional misconduct.

Your actions as set out in this charge breached provisions 16, 16.4, 17, 17.1, 19, and 19.1 of the Code. By allowing a staff member with known safeguarding risks to work unsupervised and without a risk assessment, you failed to act on concerns and protect vulnerable residents from harm.

Accordingly, the panel found that your actions in respect of Charge 6a fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

7a. Schedule G (7, 8 and 9)
7 & 8 – Service User L

The panel found that your actions in relation to Service User L demonstrated a fundamental failure to ensure safe and appropriate care in accordance with professional standards. While the care plan explicitly indicated the required use of a full-body hoist and the assistance of two staff members during transfers, you failed to implement and enforce these requirements. This was not a simple oversight, but a repeated and systemic failing that placed both Service User L and staff at avoidable risk of harm. Your failure to ensure adherence to the care plan reflected a lack of clinical oversight and a disregard for established safety protocols.

In addition, you failed to ensure that the correct equipment was used during toilet transfers, allowing the use of a toileting sling instead of a full-body sling. This practice contravened both clinical guidance and the care plan, and further exposed Service User L to an increased risk of injury. As the registered manager, you had a duty to embed safe moving and handling practices, provide effective supervision, and address unsafe behaviour - yet the evidence demonstrated that you did not do so. These failings went beyond poor practice and represented a significant breach of your professional duty to safeguard vulnerable individuals under your care.

9 – Service User D

The panel found that you failed to ensure the use of the appropriate “in situ” sling as set out in the Occupational Therapist’s (OT) report of 10 October 2019. This was a specific clinical instruction aimed at reducing risk and maintaining the service user’s safety during hoisting. However, contemporaneous evidence from Witness 3 indicated that staff were not using the prescribed sling and appeared unclear about its intended purpose. This pointed to a wider failure in your responsibility to provide adequate training, direction, and oversight. Your failure to ensure that the OT

recommendations were implemented demonstrated a lack of governance and an abdication of your leadership responsibilities. As a registered nurse and manager, your accountability extended beyond policy creation. You were responsible for ensuring that clinical instructions were communicated, understood, and consistently followed by your team.

Across all three events, your actions represented a serious departure from the standards expected of a registered nurse and amounted to misconduct. Your actions as set out in this charge breached provisions 11, 11.1–11.3, 19, and 19.1 of the Code. You failed to ensure adherence to safe moving and handling procedures, placing both residents and staff at avoidable risk due to inadequate oversight and delegation.

The panel considered that the risks associated with moving and handling are well-known within nursing and that appropriate precautions are essential to prevent harm. Your failure to uphold these responsibilities reflected a lack of leadership, clinical judgment, and professional accountability. Accordingly, the panel concluded that your conduct in relation to Charge 7a fell seriously short of the standards expected and amounted to misconduct.

Charge 15a - Schedule O (1)

As the registered manager, you held the duty to implement effective systems to monitor, assess, and improve care quality and safety. The panel accepted the evidence of Witness 3, who attended both the initial governance meeting with the CQC in September 2019 and the subsequent follow-up inspection in December 2019. At both points, clear and serious concerns were brought to your attention - concerns which spanned essential areas of operation, including care planning, fire safety, staffing levels, medication management, and risk oversight. Despite this, you failed to implement or sustain the necessary changes to address these regulatory failings.

This was not a case of isolated or newly emerging concerns. The issues had been raised repeatedly over time and were well-known to you. However, there was no

evidence that you took the steps required to ensure lasting, meaningful improvement. Instead, superficial or temporary changes were made, with no embedded governance and monitoring processes to support long-term compliance. This pattern of reactive, short-lived responses demonstrated a failure to establish the systems needed to maintain safe, effective care in your service. The panel considered that, as a registered manager, your role demanded not only administrative oversight but active leadership, strategic planning, and a commitment to continuous quality improvement.

Your actions as set out in this charge breached provisions 11, 11.1–11.3, and 25, 25.1 of the Code. You failed to identify priorities and take sustained action to address known governance failings, reflecting a serious absence of leadership and accountability.

In failing to engage with well-documented risks and in disregarding opportunities to make meaningful improvements, you placed residents and staff at continued risk of harm. Your actions demonstrated a serious lack of leadership, clinical governance, and professional responsibility. These failings went beyond poor management and reflected a departure from the standards expected of a nurse in a senior role. Accordingly, the panel found that your actions in respect of Charge 15a Schedule O (1) fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 17a - Schedule Q (1)

The panel considered the evidence regarding the hole in the floor and/or carpet that presented a potential trip hazard within the Home. It was not possible to determine how long this issue had existed. While the presence of a hole in the floor represents a concern for safety, the panel found that this issue did not reach the threshold for misconduct. Based on the evidence before the panel, your conduct as set out in this charge was not sufficiently serious to amount to a finding of misconduct.

Charge 17a - Schedule Q (2a, 2b and 2c)

The panel considered that, as the individual responsible for care plan oversight, you had a clear professional obligation to ensure that Resident M's care plan contained accurate and comprehensive information. You accepted this responsibility in your own evidence. The omissions identified - concerning diet, choking risk, hearing, and skin integrity - represented basic care needs that should have been clearly documented and regularly reviewed. These were not technical or complex errors requiring specialist knowledge. Rather, they were fundamental aspects of care that are widely recognised within nursing practice as essential for safeguarding vulnerable residents. The failure to document these areas - particularly those related to swallowing risk and pressure care - exposed Resident M to foreseeable and avoidable harm, including choking, neglect of sensory needs, and the potential development of pressure ulcers.

Your actions as set out in this charge breached provisions 10, 10.1–10.3 of the Code. You did not ensure that fundamental care risks were documented in Resident M's care plan, significantly compromising their safety and wellbeing.

The panel had regard to the NMC's guidance on misconduct, which recognises that serious concerns arise where there is a significant risk to patient safety, particularly when involving fundamental aspects of care or a failure to meet basic professional obligations. The guidance further noted that poor record-keeping can itself amount to misconduct when it leads to, or has the potential to lead to, harm. In this case, your failure to ensure Resident M's care plan contained appropriate, up-to-date information about key health risks amounted to more than a documentation error. It reflected a serious departure from the standards of practice expected of a registered nurse and manager. Accordingly, the panel found that your actions in respect of Charge 17a Schedule Q (2a 2b and 2c) fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Charge 17a - Schedule Q (3a and 3c)

The panel considered that accurate and consistent documentation of falls is essential to delivering safe and responsive care. Fall records serve not only as a record of incidents but as a critical tool for identifying risk patterns, evaluating

underlying causes, and implementing preventative strategies. The panel determined that inconsistencies between the falls record and the accident log undermined this process and created a risk of further injury, particularly given Resident J's known vulnerabilities. The panel considered that accurate falls monitoring is a fundamental aspect of a nurse's duty of care. The failure to maintain aligned and accurate records constituted a serious lapse in practice, increasing the potential for repeated, preventable incidents. This fell significantly short of the standards expected and engaged the provisions of the NMC Code relating to safe care and accurate documentation.

Further, the panel found that the failure to include dietary guidance provided by the Speech and Language Therapy (SALT) team represented a serious omission. The purpose of such guidance is to mitigate the well-known risk of choking – a potentially fatal hazard in care settings. The omission meant that staff did not have ready access to information necessary to support safe eating and drinking for Resident J. The panel considered this to be a clear breach of the duty to protect residents from foreseeable harm. As noted in the NMC's guidance on misconduct, failings that result in or risk significant harm, particularly when the harm is avoidable and preventable through adherence to known professional standards, are likely to amount to misconduct. In this instance, the lack of dietary safeguards created a real risk to the resident's safety and evidenced a serious departure from expected practice.

Your actions as set out in this charge breached provisions 1.2, 6, 10, 10.1–10.3 of the Code. You failed to record falls data accurately and omitted key dietary information, placing Resident J at risk of repeat incidents and choking.

The panel concluded that the omissions in parts (3a) and (3c) of Schedule Q placed a vulnerable resident at risk of serious and avoidable harm and reflected a failure to adhere to basic professional responsibilities. These failings fell far below the standards expected of a registered nurse and amounted to misconduct.

Charge 17a Schedule Q (3b)

Although the panel considered that the risk assessment related to self-harm, it noted that the behaviour in question was reportedly historical and that there was no evidence of a current or ongoing risk of self-harm at the time of the inspection. As such, based on the evidence before the panel, the absence of a self-harm risk assessment, while not best practice, did not amount to a failure that was sufficiently serious to amount to a finding of misconduct.

The panel noted that under the NMC's guidance, not all failings constitute misconduct. Misconduct must involve a serious departure from professional standards that impacts public protection, undermines trust in the profession, or demonstrates a disregard for fundamental responsibilities. In this instance, the omission did not meet that threshold, as it related to a historic behaviour with no evidence that the omission led to or risked harm at the relevant time.

Charge 17a - Schedule Q (4a and 4b)

The panel considered that the failures could not be considered as minor documentation errors or matters of clinical judgment. It took the view that these were significant omissions that removed key safeguards for a resident already known to be at high risk of injury and deterioration. The panel concluded that these omissions represented serious clinical failings. The lack of documented occupational therapy recommendations compromised the safety of Resident O's mobility care and increased the likelihood of unsafe manual handling. Additionally, the absence of information on skin integrity risk exposed the resident to preventable harm, including the development of pressure ulcers.

While you accepted that the OT recommendations had not been incorporated into the care plan, you asserted that they were being followed in practice. However, the panel considered that, in accordance with the NMC Code and relevant professional guidance, safe practice depends not only on what is done, but on what is clearly recorded. Documentation must be accessible, accurate, and contemporaneous to support continuity of care and enable all staff to act consistently on clinical advice. The absence of such records undermines the reliability of care and places service users at direct risk.

Your actions as set out in this charge breached provisions 1.2, 6, 10, 10.1–10.3 of the Code. You failed to include occupational therapy guidance and skin integrity risks, removing essential safeguards from Resident O's care plan.

These omissions demonstrated a disregard for clinical guidance, regulatory expectations, and the duty to protect patients from avoidable harm. The panel found that your actions fell seriously short of the standards expected of a registered nurse and amounted to misconduct.

Charge 17a - Schedule Q (6)

The panel found that you failed to investigate or respond appropriately to four similar falls experienced by Resident J. There was no evidence before the panel to demonstrate that root cause analysis was undertaken, care plan updates were made, and interventions were documented. These omissions occurred despite clear patterns indicating an ongoing risk to the resident's safety. The panel concluded that this represented a gross failure of clinical governance. The lack of action in the face of repeated incidents exposed Resident J to foreseeable and preventable harm. The failures were not only managerial but went to the core of your professional duty to safeguard vulnerable individuals and manage clinical risk.

Your actions as set out in this charge breached provisions 10, 10.1–10.3, 19, and 19.1 of the Code. You did not act on repeated falls or ensure care plans were reviewed, exposing a vulnerable resident to foreseeable and preventable harm.

The panel considered this to be a basic failure in safeguarding and risk management. The repeated nature of the incidents, combined with the absence of any documented analysis or preventative action, constituted a serious departure from the standards expected of a registered nurse. Your conduct placed a vulnerable resident at sustained and avoidable risk and demonstrated a failure to discharge fundamental duties of care. The panel found this to be sufficiently serious to amount to misconduct.

Charge 17a - Schedule Q (9)

The panel considered that you failed to document the rationale for a room-sharing arrangement, and there was no recorded evidence of a best interest decision or consent. While this fell short of expected record-keeping standards, the panel considered the nature and impact of the omission. There was no evidence before the panel to suggest that the residents involved experienced distress, objection, or harm as a result of the arrangement. Nor was there any indication that families or professionals had raised concerns at the time. Although the omission represented a shortcoming, in particular a breach of the contract with the KCC, it did not meet the threshold of seriousness required to constitute professional misconduct. The panel concluded that, while the failure to document consent for room sharing was not in line with best practice, it was not sufficiently serious to amount to misconduct.

Charge 17a - Schedule Q (10)

The panel found that despite clear identification of faulty smoke detectors in February 2019, you failed to ensure their replacement before the May 2019 inspection. You were unable to provide evidence that the issue was resolved or that appropriate action had been taken. This failure exposed residents to a serious, avoidable fire risk, compromising their safety and well-being.

In line with the NMC's guidance on misconduct, the panel considered whether your conduct amounted to a serious breach of professional standards that placed service users at risk and undermined public confidence in the profession. The panel concluded that your failure to act promptly on a clear safety hazard demonstrated a significant departure from the standards expected of a registered nurse and leader. Your actions as set out in this charge breached provisions 16, 19, and 19.1 of the Code.

You failed to resolve a serious fire safety issue involving smoke detectors, compromising resident safety and breaching your duty of care. This breach of duty reflected a failure to uphold fundamental responsibilities relating to risk management and safety governance. Having regard to the NMC's guidance on misconduct, which includes acts or omissions that place patients at risk and demonstrate a failure in

leadership and accountability, the panel found your conduct amounted to misconduct.

Charge 17b - Schedule R (1)

The panel considered that, as the registered manager, you were responsible for implementing the Action Plan issued by KCC following its inspection on 30 May 2019. Despite a clear timeframe and ongoing support, you failed to ensure that one or more essential actions were completed. These actions were directly linked to resident safety and regulatory compliance.

The panel considered that rather than taking ownership, you deflected responsibility and failed to engage meaningfully with the concerns raised. This response reflected poor leadership and a lack of professional accountability. Your actions as set out in this charge breached provisions 8.5, 8.6, 10, 10.1–10.3, 16, 16.4, 19, and 19.1 of the Code. You failed to implement a regulatory action plan, reflecting a disregard for safety improvement responsibilities and professional leadership.

The panel noted that the NMC's guidance on misconduct identifies failings that place service users at risk and demonstrate a breakdown in leadership or professional judgement as serious. Your inaction in the face of a formal action plan designed to improve safety represented a failure to engage with core aspects of your role as a registered nurse and manager. The panel concluded that your failure to implement the KCC Action Plan went to the heart of your professional responsibilities, compromised resident safety, and fell seriously short of the standards expected.

Your actions and inactions amounted to misconduct.

Charge 17b - Schedule R (2a, 2b and 2c)

In relation to charges 17b. Schedule R (2a, 2b and 2c) the panel considered that you failed to act on clear and avoidable environmental risks within the Home, including overflowing clinical waste bins posing infection risk and unsafe use of extension

leads. These issues had the potential to present direct hazards to residents' health and safety and were indicative of poor oversight in basic environmental standards. The panel considered that these failings were entirely avoidable through routine monitoring and timely intervention. The risks were visible, ongoing, and posed a particular danger to elderly and vulnerable residents who rely on staff to maintain a safe, hygienic living space.

Your actions as set out in this charge breached provisions 19, 19.1, and 19.3 of the Code. You failed to address known environmental and infection control hazards, placing residents at unnecessary risk from entirely avoidable dangers.

The NMC's guidance on misconduct is clear that failures which place service users at unnecessary risk of harm - particularly when risks are known and preventable - are likely to amount to serious professional failings. In this case, your inaction reflected a disregard for fundamental standards of infection control and environmental safety. These failings represented a serious departure from the standards expected of a registered nurse and manager. The panel concluded that your conduct amounted to misconduct.

Charge 17b - Schedule R (3a and 3b)

The panel found that you failed to act on clear and ongoing health and safety concerns, including a fire door that was found propped open and a shower room that was deemed inadequate and unsafe for residents' use. These risks had been identified but not addressed, despite your responsibility as the registered manager to ensure a safe environment.

Your actions as set out in this charge breached provisions 16, 16.4, 19, and 19.1 of the Code. You did not act on clear safety concerns relating to a fire door and unsuitable shower room, endangering the wellbeing and safety of residents.

The panel concluded that failures involving environmental safety represent serious departures from the standards expected of a nurse and registered manager. These are not minor oversights but lapses in core responsibilities that directly endanger

those in your care. The panel concluded that your failure to address known safety hazards placed residents at real and avoidable risk of harm. This constituted a serious breach of professional standards and amounted to misconduct.

Charge 17b - Schedule R (6)

The panel found that, despite the requirement for two-hourly checks for Resident K, who was a highly vulnerable individual, daily care records contained only two entries per day. Several entries were incomplete. This raised significant concerns about whether the care was delivered as planned and whether staff were adequately supervised in maintaining essential documentation.

The panel found that you failed in your duty as manager to ensure that care was properly documented, monitored, and reviewed. This was not a matter of isolated clerical error but reflected a breakdown in basic oversight and accountability.

Your actions as set out in this charge breached provisions 10.3, 11.2–11.3, 25 and 25.1 of the Code. You failed to ensure accurate documentation and oversight for a vulnerable resident, reflecting serious failings in leadership and care monitoring. The panel considered that failures in documentation and oversight, particularly those involving a vulnerable resident, represent serious professional failings. Accurate records are essential not only for continuity of care but also as a safeguard for vulnerable residents. The panel concluded that your failure to ensure appropriate recordkeeping and effective oversight in relation to Resident K demonstrated a serious neglect of your leadership responsibilities and amounted to misconduct.

Charge 17b - Schedule R (7a and 7b)

The panel found that you failed to ensure adequate supervision during mealtimes. Resident D, who required constant supervision while eating due to a known and documented choking risk, was observed eating alone. In addition, five other residents were left unattended during the same mealtime, despite known risks such as choking or falls.

The panel concluded that your failures created an evident and avoidable risk to resident safety. Choking is a well-recognised and potentially fatal risk in care settings, particularly among elderly residents with swallowing difficulties. The lack of supervision during this high-risk activity exposed residents to foreseeable and avoidable harm.

Your actions as set out in this charge breached provisions 1.2, 1.4, 11.3, 19, and 19.1 of the Code. You allowed high-risk residents to eat without supervision, exposing them to well-known choking and falls risks during a critical care activity. The panel noted that ensuring safe mealtime practices is a fundamental aspect of basic care. The failure to provide necessary supervision, particularly for a high-risk resident, constituted a serious departure from expected standards and placed residents at avoidable risk of harm.

This was a fundamental failure in delivering safe, person-centred care. The panel concluded that your conduct fell seriously short of the standards expected and amounted to misconduct

Charge 17b - Schedule R (9)

The panel found that residents were left without meaningful engagement or access to personalised activities. Only limited, generic sessions were observed, and no evidence was provided of structured planning or delivery systems. These concerns had been raised repeatedly, yet no action was taken to improve the quality of life for those in your care. As the registered manager, you had a professional duty to ensure that residents received holistic care that addressed their emotional and psychological wellbeing - not just their physical needs. The absence of adequate activity provision represented a failure to uphold this responsibility and left residents socially isolated and underserved.

Your actions as set out in this charge breached provisions 1.1–1.4, 2.1, and 3.1 of the Code. You failed to ensure that residents received meaningful and personalised activity, leading to isolation and a lack of holistic care provision.

The panel concluded that this failure compromised the dignity and wellbeing of residents and fell significantly short of the standards expected of a registered nurse and manager and amounted to misconduct.

Charge 17b Schedule R (10)

The panel noted that there were concerns regarding dietary needs for example the variety of food. The panel considered that this was poor practice and not in the best interests of the residents. However, there was no evidence of deliberate or reckless conduct, nor of serious harm resulting from these failings. While the standard of care fell short, the panel did not consider this to be a serious enough departure from the NMC Code to reach the threshold for misconduct.

Charge 18

While acting as the nurse in charge, you left the mental health unit without ensuring there was a registered nurse on site. This was a serious disregard of your professional and managerial responsibilities.

The panel noted that you were in charge of the shift and responsible for the overall clinical oversight and safety of vulnerable patients, some of whom had high levels of clinical need. By leaving the premises without arranging qualified cover, you knowingly put service users and colleagues at unwarranted risk. You abdicated your duty and left the unit unable to respond appropriately in the event of a clinical emergency. Additionally, this was a conscious decision that disregarded the fundamental duty to safeguard service users. Your actions as set out in this charge breached provision 19.1 of the Code. You left the premises without ensuring nursing cover, abandoning your clinical responsibilities and placing patients at risk in the event of an emergency.

This conduct constituted a serious breach of your leadership and safeguarding responsibilities. It placed patients and staff at risk and fell far below the standards expected of a registered nurse and shift leader. The panel found that this amounted to misconduct.

Charge 19 and 20

The panel concluded that your actions as set out in charges 19 and 20 demonstrated a clear abuse of your position of authority. You placed a junior colleague - who was subordinate to you - under improper pressure to say it was her who left the unit and not you. This created a power imbalance and implicated others in dishonest conduct. This not only compromised the integrity of the records but also the trust and safety between colleagues. These were not minor inaccuracies but deliberate actions to distort the clinical record and mislead colleagues about events that had potential safety implications.

You deliberately sought to hide that you had left the premises by instructing a junior member of staff to inaccurately state that she had been the person to return the patient. You then misled your manager about who had retrieved the patient.

Dishonesty in clinical practice is regarded as a fundamental breach of professional integrity. It undermines trust between colleagues, patients, and the profession as a whole. In this case, your dishonesty was not a passive act - it was active, intentional, and involved drawing others into the deception.

The NMC's guidance (FTP-2a) recognises that dishonesty - even if isolated - can amount to misconduct where it undermines public confidence or breaches a core tenet of the profession. The panel found that your actions met this threshold.

Your actions as set out in these charges breached provisions 10.3, 20.1–20.3, 20.5, and 20.8 of the Code. Your conduct was deceptive, coercive, and professionally unacceptable. It fell far below the standards expected of a registered nurse and amounted to serious professional misconduct. Your dishonest actions were premeditated, involved misuse of authority, and directly undermined trust in your professional practice. They represented a serious violation of the NMC Code and the expectations of a registered nurse. The panel concluded this behaviour amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2025, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional 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 must be honest and open and 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel found that limbs (a) to (d) of the Dame Janet Smith test are engaged in this case.

The panel finds that patients and colleagues were put at unwarranted risk of harm as a result of your misconduct. Your actions demonstrated serious and sustained failures in clinical oversight, fire safety, safeguarding, and care planning. These failings exposed vulnerable service users to foreseeable risk and placed colleagues in positions of unacceptable responsibility without adequate support or supervision.

The panel concluded that your misconduct has brought the nursing profession into disrepute. Your repeated disregard for regulatory standards, failure to act on concerns raised by external bodies, and inability to implement and maintain safe systems of care undermined public confidence in the profession. As a registered nurse and manager, your actions were not only unacceptable but fundamentally incompatible with the leadership responsibilities entrusted to you.

The panel found that your behaviour breached the fundamental tenets of the profession. You failed to uphold your duty to protect patients, to act with accountability, and to demonstrate integrity in your professional role. The misconduct demonstrated a lack of leadership, poor judgement, and a failure to adhere to the professional standards expected of a registered nurse.

The panel also found that you acted dishonestly. This included leaving the premises without qualified nursing cover, falsifying records to conceal your absence, and involving a junior colleague in that deception. The dishonesty was not isolated or spontaneous - it was premeditated, sustained over a number of days, and carried out in the context of an abuse of your position of authority. The panel considered this to be a serious breach of trust and professional integrity.

In considering whether you have demonstrated insight, the panel carefully examined your written reflective statement, the oral submissions you made during the hearing, and the supplementary documents you provided.

The panel noted that you made admissions to charge 18. However, while you accepted the factual basis of that charge, you did not acknowledge the seriousness of the incident or its wider implications. You did not demonstrate an understanding of how this decision put vulnerable residents and your colleagues at unwarranted risk of harm without nursing cover, nor did you reflect on the potential consequences had an emergency arisen during your absence.

In respect of the remainder of the charges which were found proved the panel considered that your overall response to them demonstrated a lack of engagement with the panel’s findings. You did not reflect on the concerns that were found proved, nor did you demonstrate any recognition of how your misconduct might have impacted the safety of service users, undermined professional standards, or damaged public confidence in the nursing profession. You did not demonstrate an understanding of why your actions were wrong or how they breached the core values of nursing practice. Instead, your reflective statement was limited in length, lacking in depth, and largely defensive in tone. It focused on what you believed had not happened or gone wrong, rather than acknowledging what had occurred, as found

proved by the panel. You did not provide any meaningful reflection on the dishonest conduct found proved in Charges 19 and 20, nor did you offer an explanation of how you might act differently in future to avoid similar failings. The panel noted that you did not apologise to this panel or to the profession, nor did you express any remorse or regret for your actions. There was no evidence before the panel that you had sought to understand or address the serious consequences of your misconduct for your patients, your colleagues, or the wider profession. Taking all of this into account, the panel concluded that you have not demonstrated any meaningful insight into your misconduct.

The panel was satisfied that the misconduct in this case is capable of being addressed, albeit the panel recognised that it is more difficult to demonstrate remediation of an attitudinal concern such as dishonesty. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice.

The panel considered the remediation evidence you presented, including a table listing various mandatory training courses. These included:

- Health and Safety (11 September 2024),
- Fire Safety (16 July 2024),
- Safeguarding Adults (31 October 2024),
- Manual Handling (13 February 2024),
- Mental Capacity (16 March 2025); and
- Infection Prevention (16 March 2025).

The panel acknowledged that some of these courses are relevant to the concerns raised in this case. However, the panel concluded that there was no accompanying evidence of reflection on your learning from these courses, how this had been applied in practice, or how it had contributed to any change in your professional approach. Nor did the panel see any targeted remediation directly addressing the dishonesty found proved or the significant leadership and governance failures.

In the absence of such evidence, the panel was not satisfied that you had undertaken sufficient or meaningful steps to strengthen your practice.

You also submitted three testimonials in support of your practice. One was a character reference dated 6 November 2024, provided by a colleague at the supported accommodation where you are employed. While the panel acknowledged the positive nature of this reference, it noted that it was unclear how long the colleague had worked with you or in what capacity. The reference did not specify the extent of the author's knowledge of the concerns raised in this case.
In addition, you provided two testimonials from service users, dated 26 December 2024 and 4 January 2025. The panel acknowledged these as positive and appreciative of the care you had provided. However, neither testimonial made reference to the allegations or suggested that the authors were aware of the nature or seriousness of the regulatory proceedings against you. As such, the panel considered that, while the testimonials reflected well on your interpersonal manner, they were of limited evidential value in the context of assessing insight or remediation.

In light of the panel's findings that you have not demonstrated meaningful insight or provided sufficient evidence of remediation; the panel concluded that a risk of harm remains. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. The panel considered that the public interest is engaged in this case given the nature, breadth and seriousness of the conduct found proved. Additionally, the panel considered a member of the public would be concerned if regulatory action were not taken against you, an experienced nurse, who had been acting in a

managerial role with vulnerable residents under your care. You have breached multiple provisions of the Code and acted dishonestly. For these reasons, the panel determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel therefore also finds your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike your name off the register. The effect of this order is that the NMC register will show that your name 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 Girven provided written submissions to the panel in which she stated:

1. "*Having found that the Registrant's Fitness to Practise is currently impaired, the next stage is for the panel to consider which sanction to impose. The panel is referred to the NMC's guidance on Sanctions- https://www.nmc.org.uk/ftp-library/sanctions/*

2. *Any sanction imposed should be proportionate and should be the least restrictive sanction required in order to protect the public and uphold the public interest. The panel should consider each sanction in ascending order, from least restrictive to most restrictive, and only move to the next sanction if it considers that the less restrictive sanction is insufficient.*

3. *The available sanctions are (in ascending order):*
    a. *No further action*
    b. *Caution order*
    c. *Conditions of practice order*
    d. *Suspension order*
    e. *Striking-off order*

4. *As set out in the notice of hearing dated 30 November 2023, the NMC's Sanction Bid is a striking off order.*

Aggravating and mitigating factors

5. *When considering what sanction to impose, the panel should consider the aggravating and mitigating factors present.*

6. *It is submitted on behalf of the NMC that the following aggravating features are present:*
    a. *A lack of any meaningful insight;*
    b. *A lack of any meaningful steps taken by the Registrant to strengthen her practice;*
    c. *The misconduct was repeated over an extended period;*
    d. *The misconduct put multiple vulnerable patients at risk of suffering harm;*
    e. *The panel has found that the dishonesty was premeditated, sustained over a number of days and included an abuse of a position of authority.*

7. *It is submitted that there are no relevant mitigating factors in this case.*

No further action

8. *It is submitted that taking no further action is not appropriate in this case as it would not address the risk to the public or uphold public interest.*

Caution order

9. *It is submitted that a caution order is also not sufficient in this case due to the panel's conclusion that a finding of impairment was needed to protect the public and also in the public interest.*

Conditions of practice order

10. *It is submitted that a condition of practice order is not sufficient in this case. The NMC's guidance states that a conditions of practice order may be appropriate when the following factors are apparent:*
    a. *No evidence of harmful deep-seated personality or attitudinal problems*
       It is submitted that there is evidence of attitudinal problems in light of the finding of dishonesty and the Registrant's ongoing lack of insight or engagement with the concerns.
    b. *Identifiable areas of the nurse, midwife or nursing associate's practice in need of assessment and/or retraining*
       Whilst it is accepted that the majority of the concerns relating to the management of the Home are identifiable areas that are in need of assessment and/or retraining, it is submitted that dishonesty is not such an area.
    c. *No evidence of general incompetence*
       It is submitted that the concerns span several key aspects of nursing, including record keeping, clinical oversight, fire safety, safeguarding and care planning. It is accepted that the concerns primarily relate to management concerns, although it is submitted that the skills are also required for nursing more generally.
    d. *Potential and willingness to respond positively to retraining*
       The Registrant has failed to demonstrate any meaningful insight or engage with the concerns. It is submitted that it is relevant that when the CQC and/or Kent Council raised concerns the Registrant failed to sufficiently act upon them.
    e. *The nurse, midwife or nursing associate has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision*
       Not relevant to this case

f. *Patients will not be put in danger either directly or indirectly as a result of the conditions*

   It is submitted that as the panel have found that there was a risk of harm to vulnerable service users and have made a finding of dishonesty, in light of the Registrant's lack of insight, patients may be put in danger if the Registrant were permitted to practise with conditions of practice.

g. *The conditions will protect patients during the period they are in force.*

   It is submitted that it is not possible to formulate conditions of practice that would sufficiently protect patients.

h. *Conditions can be created that can be monitored and assessed.*

   It is submitted that due to the breadth of concerns, including a finding of dishonesty, it is not possible to formulate conditions of practice that can be adequately monitored and/or assessed.

11. *Any conditions of practice imposed should be relevant, proportionate, workable and measurable. It is submitted that due to the level of concerns in this case and the Registrant's lack of insight, any conditions of practice would need to be so stringent as to not be workable. It is therefore submitted that a conditions of practice order is not workable.*

<u>Suspension order</u>

12. *A suspension order may be appropriate where the misconduct isn't fundamentally incompatible with the Registrant continuing to be a registered professional. The NMC's guidance provides a non-exhaustive checklist when considering whether a suspension order is appropriate.*

    a. *A single instance of misconduct but where a lesser sanction is not sufficient. This case is not a single instance of misconduct.*

    b. *No evidence of harmful deep-seated personality or attitudinal problems*

       Please see §10a above.

    c. *No evidence of repetition since the incident*

       It is accepted that there is no evidence of repetition since the incident. However, the panel is invited to consider that the Registrant has not managed a care home since the Home closed and that the misconduct

relating to the Home spans an extended period of time. Further, the dishonesty allegation relates to her employment at the Unit and so the misconduct spans two settings.

d. *The Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour The Panel has found that the Registrant has not demonstrated any meaningful insight and there is a risk of repetition.*

13. *Whilst it is accepted that a suspension order would protect the public whilst it is in force, it is submitted that a suspension order would not sufficiently uphold the public interest due to the Panel's findings. Despite concerns being raised several years ago, the Registrant has yet to demonstrate any meaningful insight or remorse. It is therefore submitted that a suspension order is not appropriate in this case.*

Striking-off order

14. *It is submitted that the only appropriate sanction in this case is one of a striking-off order. It is submitted that the concerns in this case do raise fundamental questions about the Registrant's professionalism. The panel has found that the Registrant's actions were "not only unacceptable but fundamentally incompatible with the leadership responsibilities entrusted to you". Further, it is submitted that the nature of the Registrant's dishonesty combined with her ongoing lack of insight raise fundamental questions about her professionalism.*

15. *It is submitted that public confidence in nurses cannot be maintained if a striking-off order is not made. It is submitted that a fully informed member of the public would be concerned if a nurse who does not demonstrate any meaningful insight and who has not made any meaningful attempts to remediate the misconduct were to be permitted to remain on the register. Further, it is submitted that as the dishonesty included an attempt to involve a junior colleague in the deception and was sustained over a number of days, the public would be concerned if a striking off order were not made.*

16. *It is submitted that for the reasons outlined above, that only a striking-off order will be sufficient to protect patients and maintain professional standards.*

17. *The panel is therefore invited to impose a striking-off order."*

Ms Girven provided an oral summary to supplement her submissions.

You informed the panel that you had not prepared any formal submissions regarding sanction, as you believed you had already explained the circumstances surrounding the facts of the charges that were found proved.

You stated that you do not accept the findings of fact, or the account set out by Ms Girven in her submissions concerning sanction.

The panel invited you to make submissions on sanction, particularly regarding whether there were any mitigating factors you wished to highlight, or any insight you had gained in relation to the findings. In response, you stated that you had learned a great deal through the process and had gained insight, particularly into the importance of honesty and transparency.

You stated that you were trying your best to act with integrity and that you had always intended to do the right thing. However, you found it very difficult to respond to the NMC's submissions. Although you confirmed that you had received and read both the case papers and Ms Girven's written submissions, you explained that you struggled to address each issue raised in detail.

You stated that you found it difficult to dispute the issues because you do not believe you caused any harm. You said there had never been any incidents of harm, death, or hospitalisation at the nursing home. You explained that your actions were motivated by a desire to protect patients. You reiterated that no harm had occurred and that your primary concern was always the welfare of those in your care.

You concluded by stating, through this long and difficult experience, you have come to understand the importance of being open, transparent, and honest in all aspects

of professional practice, and that this has been the most significant lesson you have taken from the process.

In light of the concerns, you raised about the difficulties in preparing a response to the NMC's submissions, the panel sought clarification as to whether you had been given sufficient opportunity to read and review them. It was confirmed that the written submissions were sent to you at 8:49am, and you acknowledged shortly before 10:00am that you had read them. You also confirmed during a pre-meeting with the legal assessor and the case presenter that you had read the submissions and were content to proceed.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- A pattern of misconduct over a period of time occurring within two separate healthcare settings
- Conduct which put patients at risk of suffering harm
- Lack of insight into failings
- Lack of steps taken to strengthen practice
- Dishonesty which was sustained and included attempts to cover up the misconduct involving a junior colleague, which was an abuse of your position of trust
- No evidence of meaningful remediation or learning from the misconduct
- Wide ranging nature of failings relating to fundamental aspects of nursing

In relation to your dishonest conduct, the panel considered the features that aggravated it as above. It concluded that your dishonesty was towards the higher end of the scale of seriousness.

The panel did not identify any mitigating features in this case.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response.

In doing so, the panel had regard to the seriousness, breadth, and attitudinal nature of the misconduct. Your failures extended across critical areas of clinical and managerial responsibility, including fire safety, safeguarding, care planning, and clinical oversight. The panel considered that these were not marginal oversights or procedural errors, but sustained, systemic failings that directly exposed vulnerable service users to foreseeable risk and placed colleagues in unacceptable positions of responsibility without appropriate supervision.

The panel acknowledged that you demonstrated care and concern for your patients. However, your approach appeared limited, lacking a deeper understanding of how

CQC and KCC regulations exist to ensure comprehensive and safe care. You failed to act on concerns raised by way of these external regulatory bodies demonstrating a persistent disregard for regulatory standards and safe systems of care. Furthermore, your misconduct did not occur in isolation but persisted even when concerns were highlighted to you. The panel concluded that this demonstrates a rooted failure to recognise and respond to serious risk.

The panel considered that your lack of meaningful insight demonstrated that a conditions of practice order would not be workable. Your continued focus on the absence of actual harm, rather than the serious and foreseeable risks your actions created, indicates a limited understanding of the core principles of safe and accountable practice. This limited perspective demonstrates a fundamental misunderstanding of the core responsibilities of your role and the preventative nature of professional standards. By failing to recognise the potential consequences of your conduct, you undermine the very purpose of regulation, which is to protect patients before harm occurs. This level of understanding raised serious concerns for the panel as to whether a conditions of practice order could be safely or effectively implemented and whether you could meaningfully comply with one. It suggests a lack of appreciation of the importance of adhering to regulatory standards and safe systems of care, which pose an ongoing risk to patient safety. In addition, the panel considered that your dishonesty would be difficult to address by a conditions of practice order due to its nature and seriousness.

The panel also took into account the evidence of training you provided at the impairment stage. Although the panel recognised that some of your training was theoretically relevant to the concerns (e.g., fire safety, safeguarding), there was no accompanying evidence to show how that learning had impacted your understanding, shifted your attitude, or led to any change in your professional practice. There was no targeted remediation of the dishonest conduct or the significant governance and leadership failures that feature centrally in this case.

Given the gravity and complexity of the misconduct, the panel concluded that a conditions of practice order would neither adequately protect the public nor uphold the public interest.

For all the reasons above, the panel concluded that there are no practical or workable conditions that could be formulated which would adequately address the seriousness of this case.

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;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel accepted that periods of suspension can serve both protective and reconstructive purposes. The panel was mindful that you have continued working (in a non-nursing capacity) within a healthcare environment. The panel considered that this was an ideal opportunity for reflection, insight development, and engagement with the expectations of your profession. Despite this, you have not demonstrated the progress expected from a practitioner seeking to re-enter the profession safely. The risk of repetition remains, particularly concerning compliance with regulation. You have not fully recognised the importance of these regulations or the reasons they exist to ensure patient safety and uphold professional standards.

Furthermore, while you have stated that you understand the importance of honesty and transparency, you have not clearly demonstrated how this understanding has

influenced your behaviour or practice. You have not provided recent examples showing how you have maintained honesty and transparency or how you keep these principles central to your professional conduct. The panel previously found your dishonesty to be deliberate, premeditated, and sustained. It involved leaving a care facility without qualified nursing cover, falsifying records to conceal your absence, and involving a junior colleague. This was an abuse of authority and a serious breach of trust. These concerns are attitudinal, and you have provided no meaningful evidence of reflection that your core understanding of professional integrity has changed.

The panel concluded that a period of suspension would not serve any useful purpose given that you have already been provided with multiple opportunities to demonstrate insight, engage meaningfully with the process, and address the concerns raised. Despite this, you have not shown the necessary progress or understanding required to ensure patient safety or uphold professional standards. The panel had no evidence before it to suggest that imposing a period of suspension would result in any meaningful improvement.

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 your actions is fundamentally incompatible with you remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel concluded that the concerns in this case do raise fundamental concerns about your professionalism. Your misconduct demonstrated serious breaches of the Code in areas central to nursing practice. You abused your position of authority in an attempt to conceal your own misconduct, to the potential detriment of others. The panel concluded that your actions, taken together, are fundamentally incompatible with continued registration. It was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to you in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is

necessary for the protection of the public, is otherwise in the public interest or in your 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 Girven. She submitted that an interim suspension order for a period of 18 months should be imposed to cover the 28-day appeal period. She informed the panel that if no appeal is made during this period, the interim order would fall away and the substantive striking off order would take effect. She further informed the panel that if an appeal is lodged then the interim order will remain in place whilst that matter is dealt with.

Ms Girven submitted that an interim order is necessary for the protection of the public and is otherwise in the public interest.

You made no submissions in relation to the NMC's application for an interim order.

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. The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28-day appeal period and the period during which an appeal is dealt with if one is lodged by you.

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

That concludes this determination.