Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday 17 November 2025 – Wednesday 26 November 2025

Virtual Meeting

Name of Registrant:	Parveen Abbas Alishah
NMC PIN:	97G1023O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – July 1997
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Angela Kell (Chair, lay member) Sharon Peat (Registrant member) Karan Sheppard (Lay member)
Legal Assessor:	Tracy Ayling KC
Hearings Coordinator:	Rene Aktar
Facts proved:	Charges 3), 6b), 7a), 7b), 8a(i), 8b(i), 8b(ii), 8b(iii), 9a), 9b), 9c(ii), 9c(iii), 9c(iv) 9c(v), 9c(vi), 9d), 9e(i), 9e(ii), 10), 11a), 11b), 12a), 12b(i), 12b(ii), 12d), 12e(i), 12e(iii), & 13).
Facts not proved:	Charges 1a), 1b), 2), 4), 5a), 5b), 6a(i), 6a(ii), 6a(iii), 8a(ii), 9c(i), 12c), 12e(ii), 14a)-h), & 15).
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Ms Alishah's registered email address by secure email on 22 September 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the fact that this meeting was to be heard virtually.

In the light of all of the information available, the panel was satisfied that Ms Alishah has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

'That you, a registered nurse, between 18 January 2021 & 2 December 2021, whilst employed as the registered manager of [PRIVATE] (the Home)

1) Did not adequately audit and/or review Resident A's care plan, which incorrectly recorded
a) Resident A could walk independently.
b) Resident A could use a Zimmer frame.

2) Did not supervise and/or train and/or monitor that staff were practising competent infection control practice, namely washing their hands regularly after washing soiled equipment in the sluice rooms.

3) Did not adequately audit and/or review Resident B's care plan, in that, Resident B's background history had not been completed.

4) Did not monitor and/or supervise that staff were providing adequate personal care to one or more residents during the morning shift.

5) Did not ensure that a system was in place to;
a) Adequately manage rotas to deploy staff at the Home.
b) Complete a dependency tool for each resident.

6) Did not put a system in place which ensured that clinical staff undertook;
a) Training in areas of;
i) Infection control
ii) Dementia
iii) Medicines management
b) Annual competency assessments.

7) Did not put a system in place which ensured that staff were adequately trained to communicate with residents, in that on one or more occasions;
a) Staff were unable to understand residents due to their lack of understanding English;
b) Staff would talk in their own language in front of residents.

8) Did not monitor and/or supervise staff to ensure that care plans for one or more residents were adequately followed and/or up to date, in that
a) In relation to Resident C, staff did not;
i) Set Resident C's pressure mattress to their most recent weight measurement.
ii) Reviewed Resident C's risk of developing pressure wounds.
b) In relation to Resident D;
i) Did not ensure that Resident D had consented to a sensor mat being placed on their floor.
ii) Allowed a sensor mat to be placed on Resident D's floor, despite Resident D having full capacity.
iii) Did not ensure that staff recorded a valid reason for Resident D not having a shower seat.

9) Did not supervise and/or monitor and/or train staff to ensure that adequate care and/or personal care was provided to one or more residents, in that;

a) Resident E's bathroom was not cleaned of urine.
b) Resident E's bed bumper remained dirty.
c) In relation to Resident F, did not ensure;
i) That staff members were cleaning Resident F's urine bottle on a regular basis whilst using septic techniques.
ii) That staff cleaned Resident F's bed bumper.
iii) That Resident F was provided with an adequate wheelchair arm.
iv) That Resident F was being showered and/or bathed as required by their care plan.
v) That Resident F was having their teeth brushed regularly.
vi) That Resident F shaved regularly
d) Staff did not ensure that Resident H was provided with a wheelchair which allowed their feet to touch the floor.
e) Staff inappropriately allowed Resident I to use;
i) Resident J's wheelchair.
ii) Resident J's pressure cushion.

10) Did not ensure that all staff members were up to date with safeguarding training.

11) Did not put into place a system and/or training to ensure that all staff members understood how recognise and/or report;
a) allegations of abuse.
b) Safeguarding concerns.

12) On 2 December 2021;
a) Did not wear appropriate Personal Protective Equipment, namely a face mask.
b) Did not monitor and/or supervise staff adequately, in that;
i) Resident B's catheter was not reviewed.
ii) Personal care had not been provided to Resident B.
c) Did not maintain the dignity of one or more female residents in that you left them sitting in the lounge without wearing bras.
d) Inappropriately allowed staff to place one or more Residents in bed by 18:00.
e) In regards to Resident I;
i) Inappropriately allowed staff to leave them in bed with no clothes on their bottom half;

ii) Inappropriately allowed staff to leave them in bed without checking on them regularly/every 30 minutes.
iii) Did not ensure that Resident I's call bell was plugged in for them to use.

13) Between 2 December 2021 and 22 March 2022, failed to implement recommendations and/or improvements raised by the Care Quality Commission.

14) In relation to Patient K did not ensure that there was a detailed care plan regarding:
a) Their skin integrity
b) The use and/or settings of a pressure mattress and/or pressure cushion.
c) Whether Patient K was bed bound
d) Repositioning requirements
e) Monthly weight records
f) Risk of dehydration
g) Medication relating to skin integrity.
h) Involvement of health care professionals when necessary.

15) In relation to Resident L, did not ensure that there was a system in place which allowed/authorised the disclosure of Resident L's records to family members

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

Background

Ms Alishah was anonymously referred to the NMC on 9 July 2021. Concerns relate to incidents which occurred at [PRIVATE] ('the Home) between 2017 – 2022. [PRIVATE] is a care home providing accommodation, personal care and nursing care for up to 78 people, aged 65 and over, many of whom may be living with dementia or a learning disability. People live in one adapted building, divided into six separate living areas, each with their own lounge and dining room.

Ms Alishah started working at the Home on 30 October 2017. She became the registered manager on 4 March 2020. As the registered manager, Ms Alishah was responsible for

ensuring that the service provided safe care to people and met the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Ms Alishah had overall responsibility for the residents, staff, and the service.

The concerns are linked to Ms Alishah's role as a Registered/Home Manager. The concerns are wide ranging and directly linked to a Care Quality Commission (CQC) investigation following inspections. The regulatory concerns are focused on her failure to provide leadership to staff to ensure care plans were reviewed and implemented, personal care was provided to vulnerable residents, safeguarding concerns were recognised and escalated, and other requisite training was delivered, as well as a failure to implement recommendations raised by the CQC.

On 8 February 2022 the CQC published their report and the overall rating for the Home was 'inadequate'. Ms Alishah left the Home in July 2022. The first CQC report pertinent to this case relates to an inspection on 18 January 2021. The outcome of the inspection was that there were five breaches of the Regulations. The overall rating for the service was 'required improvement'. The CQC had received information from visiting healthcare professionals that staff at the Home were not following infection control measures, and the local authority reported there were a number of safeguarding concerns. As part of the second inspection, on 2 December 2021, the inspectors reviewed care plans and other documentation/records, assess the environment, spoke to 15 residents, and 15 staff members. The overall rating given for the service was 'inadequate'.

The charges set out at the top of this case statement flow from the results of the CQC inspections.

The panel made reference to the inspection of 18 January 2021 and 2 December 2021, 22 March 2022. Most of the evidence comes from the inspection on 2 December 2021. An inspection included 3 inspectors, 2 of whom provided witness statements and bundles of documentation as set out above.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC. Ms Alishah had not sent any response to the charges.

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

Charge 1a)

1) Did not adequately audit and/or review Resident A's care plan, which incorrectly recorded
a) Resident A could walk independently.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement from Witness 1, the care plans, and all of the documentary evidence put before it.

The panel took into account Witness 1's witness statement which stated:

"Resident A was at risk of falls and uses a wheelchair. However, Resident A's care plan was contradictory as it said that she could walk independently when she could not. The care plan also said that Resident A could use a zimmer frame but Resident A used a wheelchair."

The panel compared this to the care plan which stated:

"Resident A is at high risk of fall as she tend [sic] *to walk independently which she cannot.*

…

Measures for transferring in or out of bed are: Will need the use of her Zimmer frame and assistance of 1-2 staff depending on how stiff she is due to OA."

Further, the care plan stated:

"I require assistance with walking.
I have a wheelchair and sometimes need assistance and often need assistance moving from place to place."

The panel took into account that the care plan makes it clear that Resident A needs to walk with a Zimmer frame and may need help from one or two staff depending on how stiff she was feeling and that for long distances she needed to use a wheelchair.

The panel determined that Resident A's care plan does not reference that Resident A can walk independently. The panel therefore found this charge not proved.

Charge 1b)

b) Resident A could use a Zimmer frame.

This charge is found NOT proved.

In reaching this decision, the panel took into account the care plan notes which stated:

"…able to weight bear and transfers with a Zimmer frame.

…

I use the Zimmer Frame for all transfers from bed to chair, chair to chair, chair to bed."

The panel took into account that it was correctly recorded that Resident A needed to use the Zimmer frame when she was not being hoisted or using a wheelchair. The panel determined that the care plan did accurately state the level of Resident A's mobility.

This charge is found not proved.

Charge 2)

> 2) Did not supervise and/or train and/or monitor that staff were practising competent infection control practice, namely washing their hands regularly after washing soiled equipment in the sluice rooms.

This charge is found NOT proved.

In reaching this decision, the panel took into account witness statement of Witness 1's where she stated:

> *"A sluice room is a room where staff wash out commodes and other equipment used at the Home. The Home is divided into six units across three floors. Each of the floors has a sluice room. One of the units at the Home is called Cedar and a sluice room was located in Cedar unit.*
>
> *When I inspect services, I expect to see sluice rooms in regular use by staff and because they should be used regularly the sinks are often still wet. I do not expect them to be bone dry."*

The panel also took account of the inspection notes dated 2 December 2021 which stated:

> *"11:12: Sluice room in Sycamore. Both sinks bone dry.*
> *13:20: Both sinks still dry in the sluice. Oak unit in the afternoon. Sink dry in sluice."*

The panel had regard of the 'Mini-staff meeting' minutes dated 21 October 2021. It stated:

> *"Most of you are complaint* [sic] *with on line training and few of you are still not complaint* [sic] *please check your training records and complete the ones showing in RED you are given the time to complete by the end of the week end…"*

The panel also had regard of the 2021 mandatory training matrix. The panel took into account that this indicates that the records show a 93.5% completion for infection control. The panel considered that there was sufficient information in the matrix to evidence that training took place.

Further, a 'Mini-staff meeting' dated 25 November 2021, which stated:

> *"The following has been discussed. Infection Prevention and Control – Hand washing and hand sanitising is very important; it is a key to the infection prevention and control. Domestic staff must make extra effort for washing and sanitising all door handles mainly in the reception, the corridors and main bathrooms and to be complaint at all times with PPE."*

The panel identified that staff were reminded of good hand washing practices. It noted that an inspector did not record seeing anyone physically go into the sluice rooms and failing to wash their hands before leaving. The panel had no evidence to indicate the number of residents with circumstances that would necessitate the use of the sluice rooms and considered that might account for the dry sinks.

The panel determined that there was insufficient evidence to prove that Ms Alishah did not supervise, train, or monitor that staff were practising competent infection control practices, namely washing their hands regularly and after washing soiled equipment in the sluice rooms.

On the balance of probabilities, the panel found that charge is found not proved.

Charge 3)

> 3) Did not adequately audit and/or review Resident B's care plan, in that, Resident B's background history had not been completed.

This charge is found proved.

In reaching this decision, the panel took into account Resident B's care plan dated 6 December 2021. It also had regard of the CQC report dated 2 December 2021 which stated:

> *"No background history on her."*

The panel also had regard to the CQC Inspection report dated 8 February 2022 which arose from the inspection on 2 December 2021 which stated:

> *"People had no information about their background in order to enable staff to get to know them. There was nothing about their previous jobs, family details, hobbies or interests."*

The panel took into account that although past medical history was completed, there was no record of the residents' social background. The documentation included a 'This is me' section to capture this information, however this was left blank. The panel took into account that the only conversation that was recorded on the inspection on 2 December 2021 which stated:

> *"Parveen said, "The information is on the initial assessment." She showed me one, which was blank."*

The panel took into account that the background information section for Resident B was blank, where no background history had been provided, despite Resident B having been at the Home for over six weeks.

The panel therefore found this charge proved.

Charge 4)

> 4) Did not monitor and/or supervise that staff were providing adequate personal care to one or more residents during the morning shift.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement where she stated:

> *"While in Resident B's room, Resident B told me that that her catheter had come apart and that she was wet. Resident B said she rang the bell to be changed, and that staff came and answered the bell but that they did not change her. Resident B sat for a long enough time for her trousers to dry out. Resident B told me that she felt like, "A lost bit of luggage. Just forgotten about".*
> *…*
> *Rotas may be requested as part of CQC inspections to check that staffing levels are in line with what CQC inspectors have been told. The CQC had received mixed feedback as to whether there were enough staff at the Home. During the inspection, I saw a housekeeper sit with residents because there were not enough care staff. I also noticed that some residents were not provided with personal care in a timely manner in the morning as they were not being supported to get up until lunchtime."*

The panel also took into account the inspection notes dated 2 December 2021 which stated:

> *"My catheter parted company this morning and I got all soggy. I am waiting to be changed. I thought they were going to come back, but I'm still waiting…Just forgotten about."*

The panel had sight of the 'Mini-staff meeting' dated 11 November 2021 which stated:

> *"All aspects of mouth care that will provide comfort and improve quality of life should be included in the patient's care plan…This should ensure continuity of care between care setting and amongst different carers."*

The panel took into account that there were no records or audits of personal care provided to them, it therefore could not determine the adequacy of the monitoring and supervision provided. Resident B was the only example provided and although the panel was of the

view that their care was inadequate, on balance, it considered that this represented a single incident/snapshot in time, rather than a systematic review.

The panel therefore found this charge not proved.

Charge 5)

5) Did not ensure that a system was in place to;
a) Adequately manage rotas to deploy staff at the Home.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 where she stated:

"However, when I reviewed the rotas I did not particularly notice that the rotas were not in line with staffing levels. This can indicate that deployment of staff at the Home is not being done properly which means that residents need to wait for care.
…
When I was at the Home, I saw evidence of dependency tools being done. I did not take a copy of these as part of the inspection. There was nothing on the dependency tools that indicated that there were not the same number of staff on rota that we had been told. However, our concerns during the inspection of there not being enough staff could mean that the dependency tools were not being done properly, that they were being ignored or not being updated enough..."

The panel also took into account the CQC inspection notes dated 2 December 2021 which stated:

"Staffing: 2 x nurses (1 on ground floor and 1 on top floor. TL on middle floor – mainly dementia and residential (plus Victor). Victor is based there. Dementia and general nurse. New position
1 x team leader
3 x care staff on each unit

2 residents 1:1 with additional staff"

Further:

> ***"Staffing***
> *2 nurses and a team leader 3 carers on each 6 units. 2 people that are 1-1. 1 or 2 doing an induction from agency. I nurse on ground floor, 1 nurse on top floor and team leader is in the middle. Middle floor is mainly dementia."*

The panel determined Witness 1's witness statement did not provide any contextual information to assist them in understanding what staff levels were needed according to the dependency tools and in comparison, with the number of staff on shift that day.

The panel noted the inconsistent information and comments from residents on staffing levels. It also considered those comments may lack objectivity. The panel determined that there was insufficient evidence to prove that the rotas were not managed adequately to deploy staff appropriately.

The panel therefore found this charge not proved.

Charge 5b)

> b) Complete a dependency tool for each resident.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 where she stated:

> *"When I was at the Home, I saw evidence of dependency tools being done. I did not take a copy of these as part of the inspection. There was nothing on the dependency tools that indicated that there were not the same number of staff on rota that we had been told. However, our concerns during the inspection of there*

not being enough staff could mean that the dependency tools were not being done properly, that they were being ignored or not being updated enough."

The panel was presented with no evidence of missing or incomplete dependency tools and furthermore, the inspector specifically noted that there is evidence of them being done. The panel therefore determined that there is no evidence to suggest that the dependency tools were not completed and the NMC had not discharged the burden of proof.

This charge is found not proved.

Charge 6)

6) Did not put a system in place which ensured that clinical staff undertook;
a) Training in areas of;
i) Infection control
ii) Dementia
iii) Medicines management

These charges are found NOT proved.

The panel considered all three of these charges separately but relied on the same evidence to find them not proved.

In reaching this decision, the panel took into account the written statement of Witness 1 which stated:

"I was concerned that the staff at the Home were not following infection control measures and that there was an infection control risk to residents, especially as the inspection took place when COVID-19 was still a concern at the time.

As the registered manager, Ms Alishah should ensure that staff are reminded of the infection control measures, and that they are trained in these measures and for ensuring that staff are competent in infection control. Ms Alishah should monitor

staff by conducting regular observations and supervision, and discussing infection control during training."

The panel also took into account the 'Mini-staff meeting' dated 14 October 2021 where it stated:

"All staff reminded about the online training to be complaint at all times, those not complaint for any reason must ensure to be complaint by next week."

The panel took into account that the training matrix demonstrated 93.5% of compliance in infection control training at the time of access and noted that at the 'Mini staff meetings' staff were regularly reminded to complete their mandatory training.

Dementia training showed 93.5% completion, and medicines awareness 93.3% at the time of access.

The panel determined that although there was no contextualisation of the training matrix, it was satisfied that there was a system in place and concluded that there was insufficient evidence to suggest that staff were not trained.

The panel therefore found these charges not proved.

Charge 6b)

b) Annual competency assessments.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 which stated:

"I also had concerns around competencies of clinical staff in relation to medicines. Nurses at the Home dispense medication so they should complete training and have their medication competency assessed once a year. As the registered

manager and a qualified nurse, Ms Alishah was responsible for doing the nurses' competencies every year. However, when I spoke to Ms Alishah about the nursing competencies, the last checks that she was able to find were in 2019. This meant that no competencies had been done for two years."

The panel noted that annual competency assessments would only be applicable for qualified nursing staff. The panel took into account that Ms Alishah came into post as the manager in 2020 and when asked by the inspectors, was unable to provide any evidence that any competency assessments had been undertaken. The panel therefore concluded that in the absence of any completed competency assessments, there was no system in place to ensure they were undertaken.

The panel therefore found this charge proved.

Charge 7a)

7) Did not put a system in place which ensured that staff were adequately trained to communicate with residents, in that on one or more occasions;
a) Staff were unable to understand residents due to their lack of understanding English;

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 which stated:

"Resident B commented that the staff at the Home did not speak English."

Further, the panel took account of the CQC inspection report notes on 2 December 2021 which noted:

"Resident B said, "The other night, I had a staff member who was British and I thought, thank goodness – someone who will understand me."

The panel also had regard to the CQC Inspection report dated 8 February 2022 which arose from the inspection on 2 December 2021 which stated:

> *"We found there were instances when staff struggled to comprehend our questions and one staff member told us, "Please be careful, my English is bad." A staff member came into one person's room whilst we were there to discuss their menu choices for the day. However, the staff member did not understand the menu and what was on offer due to their lack of English which left the person confused."*

The CQC Improvement action plan dated 2 February 2022 stated:

> *"Staff to be reminded of the requirement to speak English at handovers, supervisions and team meetings. Managers to complete regular walkabouts to monitor the use of English. Staff who require support with their English language skills are to be encouraged to take English lessons. English language skills to be assessed as part of the recruitment process for new staff."*

This was clear evidence that there had not been a system in place to ensure staff were adequately trained to communicate with residents in English and ensure they could understand residents.

The panel took into account that some staff were not fluent in English and that there were reminders for staff to speak in English. The panel determined that there was sufficient evidence to suggest that on one or more occasions, staff were unable to understand residents due to staff lack of understanding of spoken English.

The panel therefore found this charge proved.

Charge 7b)

> b) Staff would talk in their own language in front of residents.

This charge is found proved.

The panel had regard to the CQC Inspection report dated 8 February 2022 which arose from the inspection on 2 December 2021 which stated:

> *“They speak in their own language." A second person told us, "They speak in their own language. I don't think they should." A third person said, "I feel terrible when they speak their own language. I feel like they might be speaking about me."*

The panel also took into account the contemporaneous CQC inspection notes dated 2 December 2021 which stated:

> *“I feel terrible when they speak their own language. I feel like they might be speaking about me. I asked a carer for a nightie the other day and she gave me pjama* [sic] *bottoms. It agitates me.”*

Further, it noted the ‘Initial Inspection Feedback Summary’ dated 2 December 2021, which stated:

> *“Staff not always suitably trained for their role. This included staff not being able to understand people due to their understanding of English. Staff talk in their own language in front of people.”*

In the interest of balance, the panel noted it was being raised in staff meetings. On the ‘Mini-staff meeting’ record dated 18 November 2021, it stated:

> *“Spoken language: At work place is ENGLISH only, some of the residents have mentioned that staff speaking in their own language.”*

However, the panel determined that there are numerous examples within the reports, which indicated that staff were speaking in their own languages. The panel therefore found on the balance of probabilities, this charge proved.

Charge 8)

8) Did not monitor and/or supervise staff to ensure that care plans for one or more residents were adequately followed and/or up to date, in that
a) In relation to Resident C, staff did not;
i) Set Resident C's pressure mattress to their most recent weight measurement.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 which stated:

> *"I looked at the records for Resident C. When I was in the resident's room, I noticed that their pressure relieving mattress was set to a weight for 70 to 90kg… I discovered that the resident was last weighed on 27 Nov 2021 and their weight was recorded as 50.5 kg."*

The panel also took into account the CQC inspection notes dated 2 December 2021 which stated:

> *"Her mattress was set to 70-90kg*
> *According to her MUST she was last weighed on 27/11/2021 and she weighed 50.5kg."*

Further, the CQC inspection report dated 8 February 2022 from the inspection on 2 December 2021 stated:

> *"People who slept on a pressure mattress (to help protect them from developing sores) had their mattresses set incorrectly. One person who weighed 48kg had their mattress set at '160'. We asked the registered manager what this setting represented but they were unable to tell us. They consulted with the deputy manager, who in turn consulted with the housekeeper and we were told the mattress was, "Self regulating." However, we spoke with one of the nurses on duty who told us mattresses should be set in line with the person's body weight. Following our conversation, this person's mattress setting had been changed to 50kg."*

The panel took into account Resident C's weight chart which showed a weight of 50.5kg, and the photograph of the pressure mattress settings, which was set on 70-90kg.

The panel further considered the 'CQC Inspection – Improvement Action Plan' dated 1 February 2022 which stated:

> *"Managers to complete Spot Checks of Pressure Mattresses to ensure they are used correctly."*

The panel were satisfied that although care plans were being created and updated, they were not being adequately followed, especially considering that Resident C's mattress setting was incorrect. The panel took into account that daily mattress checks were to be completed and checked by the managers which were part of the action plan improvement. The panel noted that there had not been an effective monitoring system in place which would have ensured that care plans were being adequately followed. This meant that Resident C's mattress was not properly set.

The panel considered the stem of the charge and determined that the pressure mattress was not set for the resident's most recent weight. Furthermore, Ms Alishah did not know how the setting was determined when asked by the inspectors and therefore, on the balance of probabilities, did not supervise/monitor staff to ensure the care plans were followed in respect of pressure mattress settings.

The panel therefore found this charge to be proved.

Charge 8a(ii)

> ii) Reviewed Resident C's risk of developing pressure wounds.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement which stated:

"I spoke to a nurse at the Home about the resident. I do not recall the name of the nurse. The nurse was confused as to who the resident was. I checked with the nurse whether the resident was at risk of developing pressure wounds. The nurse identified that the resident had a wound in June 2021 and October 2021 on their buttock. This meant that the resident was at a greater risk of skin breakdown.
…
The resident's mattress should be on a setting based on the resident's most up to date weight. The mattress will be less effective if it is not set to the correct weight and puts the resident at greater risk of developing pressure wounds."

The panel also took into account the 'Resident C care plan re MUST, weight and temperature' which stated:

"Resident C is nursed on an airflow mattress which is set according to her body weight, mattress is checked on a daily basis.
Reposition Resident C 2 hourly during the day and 4 hours at night to prevent skin breakdown and relief pressure."

The panel had regard to the section of the care plan concerning skin integrity and noted that it had been updated twice since its initial completion date.

The panel therefore determined that there was insufficient evidence to suggest that staff did not review Resident C's risk of developing pressure wounds. The panel therefore found this charge not proved.

Charge 8b(i) & charge 8b(ii)

i) Did not ensure that Resident D had consented to a sensor mat being placed on their floor.
ii) Allowed a sensor mat to be placed on Resident D's floor, despite Resident D having full capacity.

These charges are found proved.

The panel considered both these charges separately but relied on the same evidence to find them both proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

> *"When I was in the resident's room, Resident D was sat in her chair and had a sensor mat by her feet. Resident D told me that she was not allowed to walk on her own because she had had a recent fall.*
> *…*
> *Resident D said she was worried that any movement she makes would set the sensor mat off. This gave Resident D anxiety that she would tread on the sensor mat. When I checked the resident's care plan, there was nothing in the care plan to say that the resident needed a sensor mat. Resident D had full capacity and knew that if she needed to go to the bathroom, she needed to alert staff.*
> *…*
> *I checked the resident's care plan and there was nothing in the care plan to say that she would forget to use call bell. I also noted that on page 13 and 31 of the care plan it stated the resident had full capacity."*

The panel also took into account the CQC inspection notes dated 2 December 2021 where it stated:

> *"P4: "Im not allowed to walk on my own." (noted she had a sensor mat but I don't know why as she knows the risk of walking and it almost felt a restrictive measure for her as if she moved slightly to her right with her feet it the alarm would go off and she was worried about me treading on it. There was nothing in her care plan to say she would forget and her care plan says she has full capacity). "Im at high risk of falls, makes me feel terrible having to ask to the toilet but Im petrified on my own."*

The panel also had regard to the care plan before it and noted that there were no references to falls and their prevention on these pages, nor were there any recordings of concern about Resident D's mental capacity and ability to give consent.

The panel determined that Ms Alishah did not monitor and or supervise staff to ensure care plans were adequately followed by allowing a sensor mat to be placed on Resident D's floor, despite Resident D having full capacity.

The panel therefore found both these charges proved.

Charge 8b(iii)

> iii) Did not ensure that staff recorded a valid reason for Resident D not having a shower seat.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

> *"Resident D also informed me that they could not have a proper shower because there was no shower seat and that they had to have a strip wash whilst sitting on the toilet in their bathroom. If a resident needs a shower seat to shower, there should be a record of a good reason as to why this has not been provided. I expect carers and nurses to raise this with Ms Alishah as to why a shower seat was not in place and actions taken to remedy this. There was no record of this within the care plan."*

The panel also had regard of the contemporaneous CQC inspection notes dated 2 December 2021 which stated:

> *"Theres no seat for me to sit on, makes me feel terrible." She was referencing not having a proper shower."*

The panel took account of Resident D's care plan. The panel took into account that showering a patient is basic care, and that in the circumstances, a shower seat should have been provided in a timely manner.

The panel decided that Ms Alishah should have ensured that measures were put in place to allow Resident D to shower, meet their care needs, and to protect their dignity.

The panel found that there was sufficient evidence to find this charge proved.

Charges 9a) and 9b)

> 9) Did not supervise and/or monitor and/or train staff to ensure that adequate care and/or personal care was provided to one or more residents, in that;
> a) Resident E's bathroom was not cleaned of urine.
> b) Resident E's bed bumper remained dirty.

These charges are found proved.

The panel considered these charges together as they relate to the same resident, on the same day, both pertain to cleanliness and rely upon the same evidence.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

> *"As the Registered Manager, Ms Alishah should do a walkaround of the Home and check for any issues. If Ms Alishah had done a walkaround of the Home, it would have been clear to her, as it was to me that there was a strong smell in the resident's room and that the bed bumper was dirty. If Ms Alishah was aware of this, she should be addressing these. It is not for the CQC to stipulate how these issues should be addressed. However, from experience, I would expect some action to be taken to remedy this such as asking for the bed bumper to be cleaned/replaced and a clean around the area that smelled strongly of urine."*

The panel took into account the CQC inspection notes dated 2 December 2021 which stated:

> *"P1 – He had a catheter and his bathroom smelled overwhelming of urine. I noticed his urine bottle that staff use to empty the catheter bag was on top of his toilet*

(photo). When I leaned in it was obvious this is where the smell was coming from. According to his catheter care plan (photo) staff should clean according to, 'septic techniques' I noted his bumper on the bed looked dirty with dry drips of drink down it (photo)."

The panel also had regard to the comment of the staff meeting that took place on 14 October 2021 where staff raised a problem in relation to cleaning the bed bumpers. However, the CQC inspection took place six weeks later. The panel noted that this was a reasonable timeframe for the problem to be rectified.

The panel took account of the photographic evidence and contemporaneous notes. The panel considered that there was inadequate monitoring of Resident E's bedroom and ensuite, where the smell of the urine was not managed. This was something that should have been dealt with expeditiously and maintained with continuous monitoring to ensure a clean environment for residents.

The panel therefore found both these charges proved.

Charge 9c(i)

c) In relation to Resident F, did not ensure;
i) That staff members were cleaning Resident F's urine bottle on a regular basis whilst using septic techniques.

This charge is found NOT proved.

Before considering this charge, the panel noted the discrepancy in terminology between the charge and the evidence. The panel considered that the accepted technique in dealing with such matters is *"aseptic". "Septic"* refers to something which is dirty or contaminated.

The panel took into account Witness 2's witness statement which stated:

"When I went into Resident F's bathroom, I saw the urine bottle sitting on top of the toilet cistern. I was concerned that the urine bottle was not being cleaned properly."

The panel also took into account the photograph of Resident F's urine bottle. The panel noted that the bottle sitting on the cistern was empty and did not appear to be old, stained, or marked, and does not look dirty.

The panel was not provided with any evidence of the specific technique being used to clean the bottle nor any evidence of when it was changed. The panel therefore determined that the evidence presented does not meet the burden of proof.

The panel therefore found this charge not proved.

Charge 9c(ii)

c) In relation to Resident F, did not ensure;
ii) That staff cleaned Resident F's bed bumper.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

"I also took photographs of the bed bumpers as these were very dirty."

The panel also took into account the photograph provided of Resident F's bed bumper. The panel noted that the photograph shows that the bed bumper was dirty and that the stains were most likely accumulated over time and from multiple sources. The panel considered that the Home were aware that some of the bed bumpers appeared dirty as it was raised in the staff meeting six weeks previously.

The panel had sufficient evidence to suggest that the staff did not clean Resident F's bed bumper and there was no system in place to ensure staff were supervised/monitored, or trained to do this at appropriate intervals. The panel therefore found this charge proved.

Charge 9c(iii)

c) In relation to Resident F, did not ensure;
iii) That Resident F was provided with an adequate wheelchair arm.

This charge is found proved.

The panel had regard to the photograph provided of Resident F's wheelchair arm and noted that it looked uncomfortable and that it was not fit for purpose in that its outer covering was torn, with pieces missing, which would have posed a risk to skin integrity and infection. The panel only had an extract of the care plan, but it was clear that Resident F was not mobile as he needed to be hoisted for transfers. He therefore would have been dependent on a wheelchair. The panel was satisfied that the wheelchair arm was inadequate from the photograph taken by the inspector and concluded that had staff been properly supervised, monitored or trained, this would have been identified and resolved, as Resident F had been in the care home for over two months at the time of the inspection.

The panel therefore found this charge proved.

Charge 9c(iv)

c) In relation to Resident F, did not ensure;
iv) That Resident F was being showered and/or bathed as required by their care plan.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

"…I asked Resident F how often he had a shower and bath. Resident F said that he should have one three times a week but that this does not always happens.

When I checked his bath and shower record, it said that he likes a shower every day. But in his shower record it said that in November he had not had a shower or a

bath. The shower record just refers to having a bed bath that meant that Resident F was not being provided with baths and showers as preferred by them."

The panel also took into account the CQC inspection notes dated 2 December 2021 which stated:

"[Resident F]'s care plan states he would like a shower every day. According to his bath and shower record for the month of November 2021 he had either a bed bath or a wash for the whole month. Says he is shaved every day, I have to say there wasn't a lot of growth on his face so this must be happening."

The panel considered that Witness 2's statement corroborated and was consistent with the care plan where it indicated Resident F's wish to have showers on alternate days. The panel also found that this was consistent with the contemporaneous CQC inspection notes from 2 December 2021. The panel had sight of Resident F's shower records which shows them having either a strip wash or bed bath every day in November 2021; no showers were recorded that month.

The panel therefore found this charge proved.

Charge 9c(v)

c) In relation to Resident F, did not ensure;
v) That Resident F was having their teeth brushed regularly.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

"While in his bathroom, I noticed that his shaving brush and toothbrush was bone dry which indicated that they had not been used recently. Resident F told me that he had not had his teeth brushed in quite a while. Resident F also said that he had

not had a shave. There was no evidence of any management oversight of how frequently people were being supported with their personal care."

The panel also had regard of the 'Mini-staff meeting' dated 11 November 2021 which stated:

"Staff reminded the importance of oral health care for venerable [sic] *adults, especially resident suffering with dementia, staff also encouraged to watch on oral health care…"*

The panel had regard of the fact that although some training was provided, adequate care was not given in line with the expectations or in line with the residents wishes. The panel also noted the evidence that the toothbrush was bone dry and did not appear to have been used that day.

The panel was therefore satisfied, that on the balance of probabilities, that staff were not supervised, and/or monitored to ensure that personal oral care was provided to Resident F and this charge was found proved.

Charge 9c(vi)

c) In relation to Resident F, did not ensure;
vi) That Resident F shaved regularly

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

"Resident F also said that he had not had a shave. There was no evidence of any management oversight of how frequently people were being supported with their personal care."

The panel also took into account the CQC inspection notes dated 2 December 2021 which stated:

> *"…I would like to have a shave every day though." He confirmed he hadn't had his shave that day."*

Further, Resident F's care plan notes stated:

> *"I like to have a wet shave on my face."*

The panel took into account that although Ms Alishah was not personally responsible for delivering Resident F's *"hands on"* care, as home manager she was responsible for ensuring that it was provided. The panel considered that this omission was not a single incident.

The panel found there was sufficient evidence to suggest that Resident F was not shaved regularly. The panel therefore found this charge proved.

Charge 9d)

> d) Staff did not ensure that Resident H was provided with a wheelchair which allowed their feet to touch the floor.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

> *"Resident H was sat in a wheelchair in the lounge and had her feet on a leather beanbag. When I spoke to staff at the Home, they said that Resident H rubbed her ankles together and that placing them on the beanbag helped. However, when I checked Resident H's care plan there was no mention of this…*

I spoke to Ms Alishah about this and she said that she thinks the beanbag is used because she thinks Resident H's feet do not touch the floor when in the wheelchair. I questioned whether Resident H was using an appropriate wheelchair if her feet do not touch the floor.

From our conversation, it was clear that Ms Alishah was aware that Resident H's feet were not touching the floor. Therefore, Ms Alishah should have sourced a wheelchair where Resident H's feet could properly touch the floor."

The panel also took into account the CQC inspection notes dated 2 December 2021 which stated:

"Resident H was in the lounge in the morning and was sat in her wheelchair. Her feet had been placed onto a leather looking beanbag."

Further, the panel had sight of the warning notice dated 23 December 2021 which stated:

"We spoke with the registered manager who told us they, "Assumed" it was because [Resident H]'s feet did not touch the floor when sitting in their wheelchair. As neither [a staff member] nor the registered manager were able to tell us confidentially why service user [Resident H] used a bean bag as a foot stool this meant it may not have been appropriate for her needs. It also demonstrated staff did not know people's needs well."

The panel also took into account Resident H's care plan which stated:

"I am maintaining a safe seated position in the wheelchair and my knees bend comfortably whilst foot plates in use."

The panel took into account that although it does not specifically state in the care plan that Resident H's feet should touch the floor, the assumption is that Resident H's feet should be properly supported. The panel considered that the seating provided was not aligned with the care plan and therefore Resident H's needs were not met.

The panel therefore found this charge proved.

Charge 9e(i) and 9e(ii)

e) Staff inappropriately allowed Resident I to use;
i) Resident J's wheelchair.
ii) Resident J's pressure cushion.

This charge is found proved.

These charges were considered separately, but the panel relied on the same evidence.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

"…I later noted that the wheelchair and pressure cushion she had been sitting in was from another resident's room and belonged to Resident J and therefore was not Resident I's.

This was a concern because I questioned whether it was a suitable cushion because Resident I was at risk of pressure sores. A pressure cushion should be used for the specific person sitting on it. If it is not specific, then it may not be effective."

The panel also had regard of the CQC inspection notes dated 2 December 2021 which stated:

"One person was seen in their wheelchair all day sitting on a pressure cushion. The registered manager told us they were at high risk of pressure sores. However, they were sitting on another person's pressure cushion which demonstrated staff had not ensured pressure equipment was specific for the person and their individual needs."

The panel acknowledged Witness 2's statement and noted that Resident I was sitting on the wrong pressure cushion as this was a cushion that was prescribed for Resident J. The

panel noted that contemporaneous notes were taken to state that this was the wrong pressure cushion.

Accordingly, the panel concluded that staff were not appropriately supervised, monitored or trained because they inappropriately allowed Resident I to use Resident J's wheelchair and pressure cushion. The panel therefore found these charges proved.

Charge 10)

> 10) Did not ensure that all staff members were up to date with safeguarding training.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

> *"Regarding Ms Alishah's failure to ensure staff were trained and competent to raise safeguarding concerns and their learnings from the safeguarding incidents, I would like to refer to the following:*
>
> *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Regulation 18 – states:*
>
> *18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed to meet the requirements.*
>
> *18(2)(a) Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.*
>
> *Upon review of the training matrix for the service, I found 5 staff member's safeguarding training that was overdue. Although, the remainder of the staff had*

current safeguarding training, when speaking with staff they were unable to give us examples of what may constitute a safeguarding concern and who they would report a concern to should they have concerns that someone may be being abused."

The panel had regard to the training matrix which showed that 93.5% of staff had completed their safeguarding training. Although the panel were not aware of the exact date when this data was retrieved from the system, it shows that not "all" staff were up to date with their training.

The training matrix showed that five members were not compliant with their training, and three were significantly overdue with their safeguarding training. The panel had no context whether they were absent long-term.

However, given the wording of the charge, Ms Alishah did not ensure that all staff members were up to date with their safeguarding training. Therefore, this charge is proved.

Charge 11a)

11) Did not put into place a system and/or training to ensure that all staff members understood how recognise and/or report;
a) allegations of abuse.

This charge is found proved.

In reaching this decision, the panel took into account the warning notices dated 23 December 2021 which stated:

"You had failed to ensure service users felt safe and were protected by abusive practices whilst living at your service. Service user A told us, "Some [staff] are unkind. Sometimes it's the way they speak to you. I feel safe with some, but not with all." Service user B said, "Some [staff] are rough, occasionally they grab hold of

your arms." You had not identified these potential abusive practices and therefore not taken any action or reported them to the local authority safeguarding team."

Further, the panel had regard to the CQC Inspection report dated 8 February 2022 which arose from the inspection on 2 December 2021 which stated:

"…we did not feel staff understood how to recognise potential abuse, or how to report it."

The panel also took account of the CQC inspection report dated 22 March 2021 which stated:

"Staff were able to describe to us what constituted abuse and the signs to look out for. However as in the previous inspection they were not all aware of who to report concerns to outside of the organisation in the absence of a senior member of staff. The lack of understanding of safeguarding processes demonstrated a repeated breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014."

The panel noted that on the inspection day, inspectors were not content that the staff fully understood the safeguarding measures, as noted in the inspection report:

"A staff member said, "I have no idea who the lead [safeguarding] agency is." This same staff member when asked if they knew how to whistle blow said they would have, "No idea and I don't know if I would be willing to do it." They added, "Staff are worried about speaking up."

The panel found that there was sufficient evidence to demonstrate that staff were not able to recognise or report allegations of abuse and therefore there was not a system or training in place that ensured all staff members understood how to recognise or report allegations of abuse. The panel therefore found this charge proved.

Charge 11b)

11) Did not put into place a system and/or training to ensure that all staff members understood how recognise and/or report;
b) Safeguarding concerns.

This charge is found proved.

In reaching this decision, the panel had regard to the CQC Inspection report dated 8 February 2022 which arose from the inspection on 2 December 2021 which stated:

> *“Although safeguarding concerns were raised by the service to the local authority, we did not feel staff understood how to recognise potential abuse, or how to report it.”*

The panel also had regard to the warning notice dated 23 December 2021 which stated:

> *“Staff member 2 said, "I'm sorry, I don't know" when we asked them if they could tell us what safeguarding meant. This same staff member, when asked if they knew how to whistle blow, said they would have, "No idea and I don't know if I would be willing to do it." They added, "Staff are worried about speaking up." This demonstrates you failed to ensure staff were skilled and competent to recognise and report safeguarding concerns, therefore placing service users at increased risk of abuse.”*

The panel took into account that there was a responsibility as a Home Manager to ensure all staff members understood safeguarding concerns. CQC inspectors found staff were unable to demonstrate sufficient safeguarding knowledge at the inspection on 2 December 2021, or the inspection on 22 March 2022.

The panel found therefore there was no system or training in place to ensure that all staff members understood how to recognise or report safeguarding concerns. The panel therefore found this charge proved.

Charge 12a)

12) On 2 December 2021;

a) Did not wear appropriate Personal Protective Equipment, namely a face mask.

This charge is found proved.

In reaching this decision, the panel took into account the CQC inspection notes dated 2 December 2021 which stated:

> *"On arrival Parveen was standing behind reception without a mask on. There was a screen up, but she would have had to have walked from her office to get there. Later in the morning, she brought me some paperwork in Sycamore unit without a mask on."*

Further,

> *"Parveen not wearing a mask when arrived and brought me the activity plan in Sycamore without a mask on."*

The panel took into account that this showed a pattern of behaviour as this happened on more than one occasion on a single day.

The panel therefore found this charge proved.

Charge 12b(i) and 12b(ii)

b) Did not monitor and/or supervise staff adequately, in that;

i) Resident B's catheter was not reviewed.

ii) Personal care had not been provided to Resident B.

These charges are found proved.

These two charges were considered separately but relied on the same evidence.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

> *“While in Resident B's room, Resident B told me that that her catheter had come apart and that she was wet. Resident B said she rang the bell to be changed, and that staff came and answered the bell but that they did not change her. Resident B sat for a long enough time for her trousers to dry out. Resident B told me that she felt like, “A lost bit of luggage. Just forgotten about.”*

This was consistent with the contemporaneous account provided by Resident B on the CQC inspection day, recorded in the inspection notes dated 2 December 2021.

The panel took into account that in not reviewing the catheter and not attending to Resident B’s hygiene needs at the same time, caused them to be left sitting in urine-soaked clothing for a considerable time. Ms Alishah therefore did not monitor and/or supervise staff adequately in that Resident B’s catheter was not reviewed and personal care was not provided despite the resident asking and staff being aware of his care need.

The panel therefore found these charges proved.

Charge 12c)

> c) Did not maintain the dignity of one or more female residents in that you left them sitting in the lounge without wearing bras.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

> *“I spoke to Ms Alishah about this and she said that during her 30 years of working she had never been asked about this. Ms Alishah also made a comment that when she goes home, she likes to take hers off. This comment was irrelevant as there was nothing in the residents' care plans which stated that they like to leave their bra*

off during the day. Ms Alishah also said that the residents' families do not bring any bras in for residents.

While I was in Resident J's room, I looked in her drawers and saw that there were bras there. I did not raise this again with Ms Alishah and do not know whether [Witness 1] did."

The panel also had regard to the inspection notes dated 2 December 2021 which stated:

"Later on I was able to check both…drawers in the room, both had bras in however I couldn't see any for…I didn't get the chance to check Resident H or Resident I."

The panel took into account that at no point were the residents asked whether they would like to have their bra on. The panel noted that there were no care plans or inspection notes produced which recorded such conversations with the residents.

Given the lack of any context of whether the female residents wished to wear bras or not, the panel could not determine whether their dignity had or had not been maintained.

The panel therefore determined that there was insufficient evidence to suggest that the dignity of the female residents was not maintained. The panel therefore found this charge not proved.

Charge 12d)

d) Inappropriately allowed staff to place one or more Residents in bed by 18:00.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

"Around 18.00, I went into Beech Unit to speak to staff and noticed that most people were already in bed."

The panel also took into account the CQC inspection notes dated 2 December 2021 which stated:

> *"I asked why she had been placed in bed and with bed rails up and they couldn't tell me. I asked if she could go to the lounge. There was silence and then [staff] asked Resident I is she wanted to go in the lounge or in her chair. Resident I asked what [staff] thought was best as the* [sic] *didn't want to, "Upset the boss."*

Further, the panel had sight of the warning notices dated 23 December 2021 which stated:

> *"You had failed to provide person-centred care to service users. At 18:00 we went into Beech unit and found most service users were in bed. Service user A was distressed and told us they did not want to be in bed but wanted to be in the lounge. This service user's care plan stated they liked to go to sleep at 20:30. In Cedar unit, we heard staff member 1 say to service user B, "Goodnight" despite it only being 18:15. This meant you had failed consider [service user's] needs and preferences."*

The panel determined that most patients were already in bed by 6pm. The panel considered this to be inappropriate because it was not aligned with residents' individual care plans nor with the wishes of all of the residents.

The panel therefore found this charge proved.

Charge 12e(i)

> e) In regards to Resident I;
> i) Inappropriately allowed staff to leave them in bed with no clothes on their bottom half;

This charge is found proved.

The panel had regard to the CQC inspection notes dated 2 December 2021:

"I walked past Resident I's room [sic] *room and she was in bed, no bed clothes on her bottom half just a pad. Her bottom sheet had been pulled up so most of her bottom half was just lying on the mattress* [sic]*… Staff didn't seem to know what to do. I asked why she had been placed in bed and with bed rails up and they couldn't tell me. I asked if she could go to the lounge."*

The panel noted this was consistent with the statement of Witness 2.

The panel took into account that Resident I was distressed, and her dignity was not maintained. The panel noted that this was wholly inappropriate to leave a resident with their bottom half exposed, lying on a mattress with no bedding. The panel took into account that although Ms Alishah was not personally delivering Resident I *"hands on"* care, there was seriously inadequate care provided to this resident. As the care home manager, Ms Alishah was responsible for ensuring appropriate standards of care were provided.

The panel therefore found this charge proved.

Charge 12e(ii)

ii) Inappropriately allowed staff to leave them in bed without checking on them regularly/every 30 minutes.

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

"If a resident does not have capacity and is not able to use a call bell properly, then I expect the Home to have a process in place that ensures the resident is being checked on regularly by staff. The staff should record that they have checked the resident every 30 minutes to one hour on an observation record."

The panel noted that there is not an observation schedule or chart in the evidence, nor is there a care plan that states Resident I needed to be checked every thirty minutes. The panel noted that due to no documents being provided outlining the need for or the frequency of checks, it could not know when Resident I was reviewed or attended to. Furthermore, the inspectors provided no timings in their notes for how long Resident I was left between checks.

The panel did not have sufficient evidence to find this charge proved.

Charge 12e(iii)

iii) Did not ensure that Resident I's call bell was plugged in for them to use.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

"Resident I's call bell had not been plugged in properly which meant that she could not use it to call staff. This was a risk to Resident I's safety because if something happened and she needed help, there was no way for her to call the staff."

Further, the panel took account of the CQC inspection notes dated 2 December 2021 which stated:

"She begged me not to leave her so I agreed I would use her call bell. This was at the top of the bed and out of reach. I pressed it twice and nothing happened. I pushed the lead into the wall and pressed it again and it worked. Staff came straight away. They didn't seem surprised her call bell hadn't been plugged in properly."

The panel noted that this was a contemporaneous note made when the incident occurred. The panel were satisfied that the call bell had not been plugged in, and therefore found this charge proved.

Charge 13)

> 13) Between 2 December 2021 and 22 March 2022, failed to implement recommendations and/or improvements raised by the Care Quality Commission.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 2 which stated:

> *"I found at this inspection, that the Home had not made the improvements. The inspection identified serious concerns and continued breaches which are set out within the inspection report dated 22 March 2022."*

The panel also had regard of the inspection report dated 22 March 2022 which stated:

> *"Rating at last inspection and update The last rating for this service was Inadequate (published 18 January 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider remained in breach of regulations.*
> *…*
> *At our last inspection, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a failure to manage risks associated with people in a safe way. Although some improvements had been made with written records, we continued to find concerns at this inspection in relation managing risks and supporting people safely, the provider was still in breach of regulation 12."*

The panel also had regard to the notice of cancellation dated 14 April 2022 which stated:

"You have failed to address concerns and improve the care service users receive. This is evidence of a history of failing to respond adequately to serious concerns raised by CQC."

Further, the warning notice dated 23 December 2021 which stated:

"You are required to become compliant with Regulation 9, section (1)(2)(3)(b), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 28 February 2022."

The panel took into account that the reports show that standardised requirements should have been followed. It shows that the reports went from good to inadequate and shows a clear decline between December 2021 and 2022. The panel noted that it shows a failure to implement recommendations and/or improvements.

When coming to its conclusions in relation to this charge, the panel concentrated on the allegation that the CQC had made recommendations, and the failure of Ms Alishah to implement them. It put out of its mind, its own findings of fact in relation to earlier charges, (for example charges 1, 4, and 5) acknowledging that those charges had to be proved by the NMC on the balance of probabilities.

Charge 14)

14) In relation to Patient K did not ensure that there was a detailed care plan regarding:
a) Their skin integrity
b) The use and/or settings of a pressure mattress and/or pressure cushion.
c) Whether Patient K was bed bound
d) Repositioning requirements
e) Monthly weight records
f) Risk of dehydration
g) Medication relating to skin integrity.
h) Involvement of health care professionals when necessary.

This charge is found NOT proved.

In reaching this decision, the panel took into account the supplementary witness statement of Witness 1 which, in referring to an exhibit called, 'Safeguarding request', stated:

> *"I would have expected this resident to have a detailed care plan around their skin integrity. This should include details for staff on what type of equipment this resident required to reduce the risk of their skin breaking down. For example, a pressure mattress or a pressure cushion.*
> *The care plan should contain information such as:*
> *• If the resident is bed bound;*
> *• Did the resident need repositioning and if so, how often should this happen;*
> *• What setting should the resident's pressure mattress be set at;*
> *• Monthly weight records to ensure the mattress was set in line with the resident's weight;*
> *• Did the resident require a pressure cushion and if so, what type of cushion and what was the maximum time they could safely sit on a cushion as opposed to having bed rest;*
> *• If the resident was at risk of dehydration and if so, what action should be taken to help reduce this risk;*
> *• Information about any creams/medication related to skin integrity;*
> *• Regular checks of the resident's skin to check for any breakdown; and*
> *• Any involvement of health professionals when necessary."*

The panel also had regard of the Inspection plan document dated 1 December 2021 which stated:

> *"End of life care*
> *Resident K (Elm unit)"*

The panel took into account that although photographs of Resident K's care plans were taken during the inspection, these were not provided to the panel. The panel also had particular regard to Witness 1's written statement which made no reference to Resident K.

The panel acknowledged that the document provided was unredacted and also did not refer to Resident K anywhere in the document nor mention the care plan, despite the reference in the inspection notes.

Therefore, the panel were unable to match the witness statement with the evidence and confirm this resident's identity with their care.

Having explained the difficulties with the documents and the uncertainty of Resident K's identity, due to the stem of the charge not being proved, the panel did not consider charges 12a)-h) of that charge. The panel were not given a relevant care plan for Resident K and therefore, it was unable to assess the charges or find any of the charges proved due to a lack of evidence.

The panel therefore found charge 14 not proved in its entirety.

Charge 15)

> 15) In relation to Resident L, did not ensure that there was a system in place which allowed/authorised the disclosure of Resident L's records to family members

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 which stated:

> *"Care homes are legally obligated to protect the privacy of their residents' personal data, including care plans under data protection legislation. Care homes would need to ensure that anyone requesting sight of care plans had the legal authority to do this. For example, a relative could have power of attorney in health and welfare because their family member lacked capacity. But, if the person did not lack capacity and was happy for their records to be shared, then I could see no reason for the service to withhold records."*

The panel took into account the unredacted exhibit referred to in this witness statement and noted that Resident L was not mentioned or named. The document referred to an information request from a family member, however the panel noted that the document did not refer directly to any issues relating to the disclosure of Resident L's records, nor did the safeguarding log refer to specific information sharing concerns.

The panel therefore found this charge not proved.

Fitness to practise

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

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

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

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Ms Alishah's actions amounted to misconduct. The NMC consider the following provisions of the Code have been breached in this case.

'1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.3 avoid making assumptions and recognise diversity and individual choice
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:
2.1 work in partnership with people to make sure you deliver care effectively

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

7 Communicate clearly
To achieve this, you must:
7.1 use terms that people in your care, colleagues and the public can understand
7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

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

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

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

To achieve this, you must:
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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures
19.3 keep to and promote recommended practice in relation to controlling and preventing infection
19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:
25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first
25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and

understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken'

The NMC consider the misconduct serious as Ms Alishah's actions fall significantly short of what would be expected of a registered nurse. The areas of concern identified relate to failures in managerial tasks and duties, such as:

- Inadequate audit and reviews of patients' care plans.
- Failure to ensure that staff practised competent infection control practice.
- Failure to monitor and supervise that staff were providing adequate personal care
- Failure to ensure that adequate and necessary systems were in place in relation to rotas and dependency tools, required training, and adequate communication with patients, as well as understanding and reporting abuse and safeguarding issues.
- Failure to monitor and supervise staff to ensure that resident care plans were adequately followed and/or up to date.
- Failure to ensure that staff were up to date with safeguarding training; failure to monitor and supervise staff accurately to ensure that a patient's catheter was reviewed.
- Failure to implement recommendations by the CQC to improve patient safety and care.
- Failed to ensure that patient's information was held securely, were so serious that they brought the Home to be considered 'inadequate.'

The NMC submit that this misconduct was a significant departure from the fundamental principles of the Code of prioritising people, practising effectively, preserving safety, and promoting professionalism and trust in the professions.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Ms Alishah's fitness to practise impaired on both public protection and public interest grounds.

The NMC submit that limbs 1 – 3 of *Grant* can be answered in the affirmative in this case. Limb 1 is engaged due to Ms Alishah's failure as a manager at the Home. The NMC also submit that Ms Alishah's poor leadership placed multiple vulnerable residents at the Home at an unwarranted risk of harm. Limb 2 is engaged because Ms Alishah's failures led to inadequate care being provided to multiple residents, the CQC following their inspections also found the level of care at the Home to be deemed inadequate. The NMC submit that Ms Alishah is liable to bringing the nursing profession into disrepute. Limb 3 is engaged because through her extensive failures in managing the Home. The NMC submit that Ms Alishah breached the fundamental tenets of prioritising people, practising effectively, preserving safety, and promoting professionalism and trust in the professions.

The NMC consider that Ms Alishah has displayed limited insight, where she has not engaged at the local level, provided a formal response to the NMC's concerns, and does not wish to participate in a hearing. Ms Alishah has not presented evidence of safe and effective practice, nor has she presented evidence of her undertaking any relevant training in respect of the regulatory concerns. The NMC submit that the public protection component remains engaged, and she has not worked as a nurse since 2022. The NMC consider that there is a continuing risk to the public due to Ms Alishah's lack of insight, failure to address the regulatory concerns, and having not had the opportunity to demonstrate strengthened practice through work in the relevant area.

The NMC consider that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Ms Alishah's conduct engages the public interest because her actions fell below the professional standards required of a nurse. The NMC submit that Ms Alishah's conduct engages the public interest because members of the public would be appalled to hear that a nurse who neglects her managerial duty to such an extent as to bring the Home's level of care to 'inadequate' is permitted to continue to work without restrictions.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000]

1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.3 avoid making assumptions and recognise diversity and individual choice*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> *1.5 respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> *2.1 work in partnership with people to make sure you deliver care effectively*
> *2.2 recognise and respect the contribution that people can make to their own health and wellbeing*
> *2.3 encourage and empower people to share in decisions about their treatment and care*
> *2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *To achieve this, you must:*

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times
To achieve this, you must:
4.2 make sure that you get properly informed consent and document it before carrying out any action

7 Communicate clearly
To achieve this, you must:
7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

8 Work co-operatively
To achieve this, you must:
8.2 maintain effective communication with colleagues
8.4 work with colleagues to evaluate the quality of your work and that of the team
8.5 work with colleagues to preserve the safety of those receiving care

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
To achieve this, you must:
9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

11 Be accountable for your decisions to delegate tasks and duties to other people
To achieve this, you must:
11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.4 take account of your own personal safety as well as the safety of people in your care

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

To achieve this, you must:

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

To achieve this, you must:

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

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

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

To achieve this, you must:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

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

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.5 treat people in a way that does not take advantage of their vulnerability or 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

To achieve this, you must:

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

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

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

In relation to charge 3), the panel found that although the stem of this charge related to a failure to audit, review, and an incompletion of the document, this did not amount to serious misconduct.

In relation to charge 6b), the panel found that despite the circumstances surrounding the COVID-19 pandemic, the risks associated with nurses not having competency assessments completed were potentially significant due to the risk of drug errors such as overdosing, underdosing, and omissions. This charge therefore amounted to serious misconduct.

In relation to charge 7a), the panel found that communication is a fundamental part of caring, especially for vulnerable individuals. The panel determined that the failure to ensure staff could understand English amounted to serious misconduct because there was

a likelihood that staff could not understand and meet residents' care needs, respond to emergencies, or communicate with each other.

In relation to charge 7b), the panel found that although it was not acceptable that patients felt uncomfortable that staff were not speaking in English, it did not amount to serious misconduct on Ms Alishah's part.

In relation to charge 8a(i), the panel found that Ms Alishah did not monitor/supervise staff to ensure care plans were followed. The pressure mattress for Resident C was supposed to mitigate the risk of developing pressure sores, but the use of the wrong setting resulted in an elevated risk. The panel determined that this was sufficiently serious so as to amount to serious misconduct.

In relation to charges 8b(i) and 8b(ii), the panel found that this was serious misconduct because Resident D felt their movement was restricted. The panel noted the inspection report where it referred to this as an *"unduly restrictive act".* Restriction of freedoms are only permissible following deprivation of liberty assessments, and decisions. Resident D had no such assessments and decisions recorded and as such amounted to serious misconduct.

In relation to charge 8b(iii), the panel found that although this was not optimal, it was not serious enough to amount to misconduct.

In relation to charge 9a), the panel found that Ms Alishah's lack of action compelled Resident E to reside in an offensive smelling and unpleasant environment. The panel determined that this amounted to serious misconduct.

In relation to charges 9b) and 9c(ii), the panel found that the bed bumper remained dirty for a considerable amount of time and that it was still dirty at the time of inspection. The panel determined that the bed bumpers were in daily use and that dirty bed bumpers posed an ongoing risk to the residents' health. The panel considered this was serious risk and amounted to serious misconduct.

In relation to charges 9c(iv), 9c(v) and 9c(vi), the panel found that there was limited evidence presented to the panel in relation to Resident F's hygiene. The panel noted that there was no evidence that Resident F was left soiled or dirty. The panel took into account that the chart indicated that Resident F had been strip washed frequently. The panel determined that although this was poor practice and not in keeping with Resident F's wishes, it did not meet the threshold for serious misconduct.

In relation to charge 9d), there was limited information about Resident H. The panel were also not aware of any potential harm or how comfortable it was for Resident H. The panel determined that this did not amount to serious misconduct.

In relation to charge 9e(i) and 9e(ii), the panel took into account that Resident I was using another resident's wheelchair and pressure cushion. The panel determined that this was potentially detrimental to both residents as neither of them were receiving the correct pressure area care and the swapping of this equipment also posed a significant risk of cross infection to these vulnerable residents. The panel considered these elevated risks of harm due to staff not being trained, supervised and/or monitored in the use of appropriate equipment amounted to serious misconduct.

In relation to charge 10), the panel found that five staff members were not up to date with safeguarding training. However, when looking at the staffing trained levels of 93%, and considering the circumstances of the COVID-19 pandemic at the time, it noted majority of the staff were trained on safeguarding. The panel determined that this did not amount to misconduct.

In relation to charges 11a) and 11b), the panel found that Ms Alishah did not ensure that staff members fully understood how to implement and apply their online training, particularly how to recognise and report allegations of abuse and safeguarding concerns. The panel considered this to be serious due to the nature of the residents in the home and the level of their vulnerability. The panel determined that failing to ensure staff's understanding around safeguarding practice amounted to serious misconduct.

In relation to charge 12a), the panel found that Ms Alishah's conduct took place several times on the same day where she did not wear PPE, especially in an environment with

vulnerable residents. The panel noted that Ms Alishah did not lead by example as the home manager and that this took place in front of the inspectors. Given the circumstances of COVID-19 and the heightened anxiety at the time, the panel determined that this amounted to serious misconduct.

In relation to charge 12d), the panel found that residents were deprived of liberties as they were not free to make their own choice regarding what time they wished to go to bed. The panel noted that communication and collaboration with residents was poor in this regard. The panel took into account that staff did not adhere to residents' wishes or care plans. The panel determined that allowing staff to put residents to bed at 6pm against their will, amounted to serious misconduct.

In relation to charge 12e(i), the panel found that a resident was left on the bed with the bottom half completely uncovered with only a continence pad thus leaving the resident in a completely undignified and vulnerable condition. This resident had bed bumpers in place and was unable to protect her privacy herself. The panel therefore determined this amounted to serious misconduct.

In relation to charge 12e(iii), the panel found that Resident I was unable to summon help as the call bell was out of use and unplugged. The panel took into account that Resident I was unable to get out of bed due to the bed rails being up and would have been unable to summon help in an emergency or for care. The inspector noted the distressed state that Resident I was in. The panel therefore determined that this amounted to serious misconduct.

In relation to charge 13), the panel found that regulations were not followed and recommendations from the CQC were not implemented. This caused the home to continue to deteriorate in its safe and effective care, even after the inspection and improvement action plan had outlined in detail the changes that needed to be made. By failing to make these improvements, residents were left with high levels of risk of harm across wide ranging areas of their environment and the care being given. The panel determined that this amounted to serious misconduct.

The panel found that Ms Alishah's actions and omissions did fall seriously short of the conduct and standards expected of a nurse and amounted to serious misconduct.

The panel were of the view that the misconduct collectively was at the more serious end of the spectrum because of the risk of harm associated with Ms Alishah's misconduct. Ms Alishah was responsible for a large number of highly vulnerable residents many of whom were unable to advocate for themselves. Her failure to monitor, supervise or train staff adequately and to ensure that resident's care plans were met, alongside her disregard for simple infection control measures put these vulnerable residents at risk of harm. The panel considered the failure to implement the improvements and/or recommendations stipulated by the CQC particularly serious because the CQC highlighted specific issues and risks which were remediable. The failure to address these issues and risks unnecessarily exposed residents to ongoing risk for a prolonged period of time.

Decision and reasons on impairment

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

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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/their fitness to practise is impaired in the sense that S/He/They:

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) *….'*

In relation to limb a), the panel took into account that there was a risk of harm to a large number of residents, in particular vulnerable residents. The panel noted that Ms Alishah exposed those vulnerable residents to unacceptable risk of harm because she did not supervise or train staff as the care home manager as:

"staff did not always know people or take time to read their care plans to familiarise themselves with risks associated with people."

Furthermore:

"people were not always kept free from harm due to staff's lack of understanding and knowledge of people's care plans or potential risks."

The lack of supervision/monitoring and/or training in respect of providing care to vulnerable residents exposed these residents to unnecessary and unacceptable risk of harm both physically and psychologically.

In relation to limb b), the panel took into account that the misconduct has brought the nursing profession in disrepute by failing to ensure that the appropriate care was provided for vulnerable residents. This was a serious falling short of the standards expected of a registered nurse and a registered care home manager. The public would be shocked to know that a nurse failed in this manner and the reputation of nurses would be adversely affected, decreasing the public confidence in the profession.

In relation to limb c), the panel took into account that the conduct breached a number of fundamental tenets of the profession. Ms Alishah failed to prioritise the people she was ultimately responsible for by ensuring individualised care was provided and by not promoting their well-being. The panel considered that as Ms Alishah was the care home manager, it was her duty to provide this care to the residents at the home. The panel also took into account that there is no evidence of audits or feedback forms, other than the training that was provided at the 'Mini meetings' which meant she had no evidence regarding how residents were being cared for in practice. The panel considered that Ms Alishah did not act upon specific recommendations or take the necessary action to remedy the issues despite feedback provided by the CQC. The panel further took into account that Ms Alishah did not promote professionalism and trust by leading by example nor by ensuring that staff adhered to minimum standards of practice.

The panel decided that the first three limbs of Grant are engaged in the past.

The panel took into account that although Ms Alishah could potentially take steps to remediate her actions, there was no evidence before the panel in relation to insight and remediation. The panel had sight of an email communication between the NMC and Ms Alishah which stated:

> *"I don't remember anything about this case, [PRIVATE] I have not been able to response* [sic] *to your previous emails and I won't be able to attend the hearing in September.*

…
[PRIVATE] I have stopped working since 2022."

The panel also considered that Ms Alishah [PRIVATE], but no further information was put before the panel about this. The panel took into account that Ms Alishah has not taken any steps to address the concerns raised in the charges found proved.

The panel considered that the conduct would be highly likely to be repeated in the future, due to there being no evidence of learning, training and change, positive testimonials, insight, or training since the time of the charges. The panel is of the view that there is a risk of repetition due to a lack of evidence on change, remediation or insight. 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, in this case, a finding of impairment on public interest grounds was required given the nature and extent of Ms Alishah's misconduct involving vulnerable residents. It determined that Ms Alishah's conduct has brought the profession into disrepute.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of one year. The effect of this order is that the NMC register will show that Ms Alishah's registration has been suspended.

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.

Representations on sanction

The panel noted that in the Notice of Meeting, that the NMC had advised Ms Alishah that it would seek the imposition of a suspension order if it found Ms Alishah's fitness to practise currently impaired.

The NMC state that the aggravating factors are:

- Failure to implement CQC recommendations following inspections.
- Failure to safeguard multiple vulnerable residents.
- Ms Alishah was in a position of seniority as the registered manager and failed to protect the interest of vulnerable residents.
- Failure to conduct adequate changes after recommendations from internal staff members.
- Lack of remediation, remorse and insight.
- Failure to demonstrate a prolonged period of safe and effective practice.

The NMC state that there are no mitigating features present.

Decision and reasons on sanction

Having found Ms Alishah's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of position of authority where Ms Alishah was responsible to provide care to vulnerable residents who were put at direct risk of harm
- Lack of insight
- Pattern of conduct over a period of time

The panel also took into account the following mitigating feature:

- The events occurred during the latter stages of the COVID-19 pandemic when there were significant pressures within the care home sector, however there was no evidence to suggest that staffing in the Home was problematic at this time.

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.

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

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

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

- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given Ms Alishah's lack of engagement with the proceedings.

Furthermore, the panel concluded the placing of conditions on Ms Alishah's registration would not adequately address the seriousness of this case and would not protect the public nor meet the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *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 was satisfied that in this case, whilst it was not a single instance of misconduct, on balance, the misconduct was not fundamentally incompatible with remaining on the register because the panel considered the conduct to be remediable. This provides Ms Alishah with further opportunity to demonstrate insight, remorse, and remediation.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and knowing the details of the case, on balance the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Ms Alishah's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Ms Alishah. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of up to one year was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Evidence of a reflective piece showing insight and reflection on the impact on residents, the nursing profession as a whole, and the public confidence
- Testimonials attesting to her workplace practice and professionalism

- Evidence of training in the relevant areas including, but not limited to safeguarding, dignity, leadership, infection control, and pressure sore prevention
- Ms Alishah's engagement with the NMC

This will be confirmed to Ms Alishah in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Alishah's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC. The NMC state:

> *'If a finding is made that Ms Alishah's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *If a finding is made that Ms Alishah's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registrant we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'*

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 suspension 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 suspension order. The panel therefore imposed an interim suspension order for a period of 18 months due to cover any potential appeal period.

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

That concludes this determination.