Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ (21 July – 1 August 2025);
Virtual Hearing (22 & 24 September 2025, 6 – 10 October 2025, 3 – 4 November 2025, 10 – 14 November 2025, 22 June – 8 July 2026)

Name of Registrant:	**Margaret Jane Cooper**
NMC PIN:	89A2800E
Part(s) of the register:	Registered Nurse, Sub Part 1 RN1: Adult, Level 1 (20 April 1992)
Relevant Location:	Norfolk/Great Yarmouth
Type of case:	Misconduct
Panel members:	Sarah Lowe (Chair, Lay member) Sarah Morgan (Registrant member) Jim Kitson (Lay member)
Legal Assessor:	Nigel Ingram (21 July – 1 August 2025); Graeme Dalgleish (22 – 24 September 2025, 3 – 4 November 2025, 10 – 14 November 2025) Charlene Bernard (6 – 10 October 2025) Michael Levy (4 November 2025) Attracta Wilson (22 June – 8 July 2026)
Hearings Coordinator:	Clara Federizo (21 July – 1 August 2025); Emily Mae Christie (22 – 24 September 2025) Anya Sharma (6 – 10 October 2025, 3 – 4 November 2025, 10 – 14 November 2025, 22 June – 8 July 2026)
Nursing and Midwifery Council:	Represented by Anthony James, Case Presenter (21 July – 1 August 2025), and James Edenborough, Case Presenter (22 September 2025, 3 – 4 November 2025, 10 – 14 November 2025) Selena Jones (22 June – 8 July 2026)

Mrs Cooper:	Not present and unrepresented
No case to answer:	Charges 7a, 7b(i), 7b(ii), 9a, 9b and 11b
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1n(i), 1n(ii), 1n(iii), 1n(iv), 1n(v), 1n(vi), 2a, 2b(i), 2b(ii), 2b(iii), 2b(iv), 2b(v), 2b(vi), 2b(vii),2b(ix), 2b(x), 2b(xi), 2b(xii), 2b(xiii), 2c(i), 2c(ii), 2c(iii), 3a, 3b, 3c, 3d (in its entirety), 3e, 3f, 3g, 4a, 4b, 4c(i), 4c(ii), 5a, 5b, 6a, 6b, 6c, 6d(i), 6d(ii), 6d(iii), 8a, 8b, 10a, 10b, 13a, 13b, 13d, 13e, 13h, 13 j, 13k, 13l(i), 13l(ii), 13m, 13n(i), 13n(iii), 13n(iv), 13n(v), 13n(vi), 13n(vii), 13n(viii), 14, 15, 16, 17a, 17b, 17 c and 18a
Facts not proved:	2b(viii), 11a, 11c, 12, 13c, 13f, 13g, 13i, 13 n (ii) , 17 d and 18 b
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Cooper was not in attendance and that the Notice of Hearing letter had been sent to Mrs Cooper's registered email address by secure email on 20 June 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and venue of the hearing and, amongst other things, information about Mrs Cooper's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Cooper

The panel next considered whether it should proceed in the absence of Mrs Cooper. It had regard to Rule 21 and heard the submissions of Mr James who invited the panel to continue in her absence.

Mr James referred the panel to the medical evidence submitted by Mrs Cooper and her email correspondence. Particularly her most recent email, dated 4 July 2025:

> *'I am confirming that I will not be attending the hearing either remotely or in person [PRIVATE]...*

I would very much appreciate all the evidence I have sent to you over the last week being placed before the panel in my absence. I also reiterate that staffing levels over my last few months working at Lound Hall were out of my control, I was not involved in the recruiting process and could only work with what I had.'

Mr James submitted that as Mrs Cooper has not attended, instructed a representative or requested an adjournment despite engaging with the NMC via email and sending documentation for the panel to consider, Mrs Cooper had voluntarily absented herself from these proceedings. He also outlined that there is a public interest in the expeditious disposal of this case, particularly as the allegations took place in 2017, and there are witnesses arranged to attend.

The panel has decided to proceed in the absence of Mrs Cooper. In reaching this decision, the panel has considered the submissions of Mr James, the correspondence from Mrs Cooper and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Cooper has corresponded with the NMC and confirmed she will not be attending the hearing [PRIVATE];
- No application for an adjournment has been made by Mrs Cooper;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Six witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2017;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Cooper in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Cooper's decision to absent herself from the hearing, albeit on medical advice. The panel found she had waived her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Cooper. The panel will draw no adverse inference from Mrs Cooper's absence in its findings of fact.

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

During the course of the hearing, Mr James made a request that this case be held partly in private on the basis that [PRIVATE] will be referred to in relation to subsequent applications he intends to make, namely proceeding in absence and admissibility of hearsay evidence. This application was made pursuant to Rule 19 of the Rules.

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

The panel determined to go into private session in connection with any references made in relation to [PRIVATE], as and when such matters are raised, in order to protect the Mrs Cooper's and witnesses' privacy and confidentiality.

Decision and reasons on application to amend the charge

Following the panel's suggestion for the NMC to consider amendments to the charges, the panel heard an application made by Mr James to amend the wording of charges 3b, 6b, 10b, 13g, 13h, 13(l)(ii), 17d and 18 for this case. The proposed amendments were as follows:

'That you, a registered nurse:

…

3 In relation to Resident C:

…

*b) **From 26 September 2017,** following identification of inflammation around their catheter, failed to ensure there was a related wound management plan in place.*

…

6 In relation to Resident F:

…

*b) Having been requested to provide a pressure ~~mattress~~ **mat**, failed to ensure that a pressure ~~mattress~~ **mat** was provided and/or that a pressure area care plan was in place.*

…

10 In relation to Resident K:

…

*b) **In early 2017,** following weight loss of approximately 10kg since admission, failed to ensure that referral to a dietician was made.*

…

13 In relation to Resident O:

…

g) Failed adequately or at all to ensure that Abbey Pain Scale documentation ~~was completed~~ for Resident O was completed daily.

*h) Failed to ensure that Resident O was weighed **and**/or weights were recorded between November 2016 and June 2017.*

…

l) Failed to ensure that wound care documentation for Resident O was sufficiently complete to make clear:

…

*ii) What if any management of the pressure ulceration referred to at ~~14 d) i)~~ **13 l) i)** above there was until 18 October 2017.*

17 On or about 27 October 2017, in an email to the CQC, made one or more of the following representations directly or indirectly, which were not accurate:

…

*d) You had ascertained the matters at charges ~~2~~ **17** a)-c) above by carrying out checks yourself*

*18 One or more of your representations at charges ~~2~~ **17** above was dishonest and/or*
lacked candour in that:
…'

Mr James submitted that the majority of the proposed amendments were minor, largely cosmetic or served to bring greater specificity to the wording and therefore would not cause any injustice or prejudice to Mrs Cooper.

Mr James submitted that the only amendment which made a material difference was the change to charge 6b, which clarified that the concern related to a pressure mat rather than a pressure mattress. He outlined that this was consistent with Elena Marin's police statement in the evidence before the panel and that the evidence matrix shared with Mrs Cooper had already set out this point clearly.

Mr James acknowledged that Mrs Cooper had not been given advance notice of the proposed amendments. However, during the course of the proceedings, the NMC notified Mrs Cooper in relation to the proposed amendments to the charges to provide an opportunity for her to consider and respond to this application. Mr James submitted that no response or objection was received from Mrs Cooper.

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

The panel was of the view that such amendments, as applied for, were in the interests of justice. It determined that the amendments provided necessary clarity and specificity, especially in relation to dates, to understand the timeframe during which each incident allegedly occurred. This would ensure that the charges are clear and precise, but without introducing any new evidence. The panel also considered that the only substantive change was the pressure ‘mat’ in charge 6b, but it determined that this merely corrected the charge to reflect the evidence that is already before the panel.

The panel considered that the NMC had provided notice to Mrs Cooper during the course of this application. Although Mrs Cooper did not respond, the panel considered that Mrs Cooper had been given clear notice of the precise charges that the panel will consider at the fact-finding stage. The panel was therefore satisfied that there would be no prejudice to Mrs Cooper, and that no injustice would be caused to either party by allowing the amendments.

Accordingly, the panel considered it fair to both parties and appropriate to grant the application to amend as requested, in order to ensure the charges are clear, accurate and properly reflect the evidence before it.

Decision and reasons on application to adduce hearsay evidence

The panel heard an application made by Mr James under Rule 31 to adduce the following evidence as hearsay:

(a) The witness statement and exhibits of Stephanie Patience; and

(b) The evidence relating to Suffolk Constabulary

Mr James made the following submissions orally and in writing:

'The Evidence of [Stephanie Patience]

2. *[Stephanie Patience]'s evidence is useful background evidence for the Panel as it explains the chronology of the CQC investigations into the Home. Further to this, [Stephanie Patience]'s work with the Home allowed her to be able to exhibit all of the patient documentation in the case (albeit this was actually seized by police). Indeed, a list of all of that material can be found at the end of her witness statement.*

3. *[Lucy Botting] has reviewed those patient records, which are uncontroversial documents to produce her reports. Those reports form the basis of the majority of the charges.*

4. *For that reason, it is the NMC's submission that [Stephanie Patience]'s evidence is accordingly uncontroversial in that regard. Indeed, the Panel will note the amount of redactions carried out by the NMC to ensure that [Stephanie Patience]'s witness statement is such. The key evidence from [Stephanie Patience] is her exhibiting the patient records that the Panel will consider.*

5. *However, it is accepted that [Stephanie Patience]'s evidence is sole and decisive in respect of the following charges:*

    (a) Charge 7;

    (b) Charge 9;

    (c) Charge 11;

    (d) Charge 12;

    (e) Charge 17 for Ms Cooper.

Police Evidence

6. *This evidence is certainly uncontroversial and is essentially relied on to provide a degree of continuity as regards records. It is not evidence that would be the subject of cross-examination if the registrants were in attendance.*

Legal Framework

The Rules

7. *The sole requirements for admissibility of evidence in the Rules are "relevance and fairness" and "whether or not such evidence would be admissible in civil proceedings" (r31(1)).*

NMC Guidance

8. *The NMC has issued guidance in respect of evidence at DMA-6. The following passage is of assistance:*

> *Hearsay evidence is not in-admissible just because it is hearsay in our proceedings. However there may be circumstances in which it would not be fair to admit it, for example where it is the sole and decisive evidence in respect of a serious charge and it isn't 'demonstrably reliable' and not capable of being tested.*[1]
>
> *Hearsay statements will usually carry less weight than oral evidence because it cannot be tested. Hearsay evidence may also be inadmissible where the weight which could be given to it in the circumstances of the case is zero, even where there is other evidence that could 'corroborate' (or support) it.*[2] *Although it's not possible to provide a complete list of situations where this could happen, one example is where the evidence of a crucial witness is hearsay, and the fact that the nurse, midwife or nursing associate can't challenge it is so unfair that nothing else in the hearing process can avoid the unfairness.*

Case Law

9. *Thorneycroft v NMC [2014] EWHC 1565 (Admin) at [56] offers a helpful outline for the Panel of some considerations before admitting hearsay evidence:*

(a) whether the statements were the sole or decisive evidence in support of the charges;

(b) the nature and extent of the challenge to the contents of the statements;

(c) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;

(d) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;

(e) whether there was a good reason for the non-attendance of the witnesses;

(f) whether the Respondent had taken reasonable steps to secure their attendance; and

(g) the fact that the Appellant did not have prior notice that the witness statements were to be read.

<u>Sole and Decisive</u>

10. The majority of the evidence against the registrants is contained within the patient records as analysed by Ms Botting.

11. If [Stephanie Patience] were to attend, she would not be able to give evidence as regards those records because she was not the person carrying out any care, she simply exhibits those documents. Their admission is accordingly uncontroversial.

12. However, as set out above, her evidence is sole and decisive for some charges. The Panel is therefore asked to consider the following:

(a) [Stephanie Patience] is a professional CQC inspector with no reason to fabricate evidence against the registrants;

(b) [Stephanie Patience]'s witness statement is corroborated by contemporaneous documentation is therefore more likely to be reliable;

(c) The registrants have voluntarily absented themselves and therefore there is no cross-examination to be put to [Stephanie Patience];

(d) Both of the registrants have been able to submit responses in writing and have no sought to challenge [Stephanie Patience]/the CQC's evidence.

13. *As regards Charge 17 for Ms Cooper, the Panel will note that Ms Cooper has provided a detailed response to that charge (**Bundle 8 page 2078**), where she does not dispute the content of the email sent (**Bundle 1 page 470**) or the fact that the content was inaccurate. What she disputes is that she was dishonest, which is a matter of judgement for the Panel that [Stephanie Patience] cannot comment on. Accordingly, [Stephanie Patience]'s evidence on this charge is also uncontroversial.*

Challenge

14. *It is unclear what the registrants may seek to challenge in [Stephanie Patience]'s evidence. In any event, their decision not to attend this hearing means that they are not going to challenge the evidence in any event* (sic). *As stated above, there is little in the residents' records that [Stephanie Patience] can be challenged about given she merely exhibits them.*

Fabrication

15. *There is no reason to suggest [Stephanie Patience] has fabricated any part of her evidence.*

Good Reason/Steps to Secure Attendance [Private]

16. *The hearsay bundle outlines in detail the steps the NMC has taken to secure [Stephanie Patience]'s attendance.*

17. *It is submitted that there are good reasons for [Stephanie Patience]'s non-attendance:*

*(a) [Stephanie Patience] [PRIVATE](**Hearsay Bundle page 22**);*

(b) *[Stephanie Patience] gave birth on 28 April 2025 and has [PRIVATE](**Hearsay Bundle page 22**);*

(c) *[Stephanie Patience] has [PRIAVTE] for 23 July 2025 (**Hearsay Bundle page 24**);*

(d) *[Stephanie Patience] in an email dated 17 June 2025 has outlined her issues…*

(e) *In any email dated 15 July 2025, [Stephanie Patience] set out as follows: "NMC have seen it proper to wait almost 8 years since the original referral was made so I do not understand the rush now. I'm unclear why my statement cannot just be read in my absence because given the passage of time I would not be answering any questions anyway, as i don't remember the facts of the case. As I've said numerous times my baby is still very young, and I have no childcare due to living far from family. It's inappropriate and unsafe to place a child of this age in a childcare facility. I am more than happy to help NMC at hearing during a more appropriate time if it cannot go ahead without me. If it must go ahead next week, please get someone to read my statement as I will not be able to attend the hearing." (**Hearsay Bundle page 1**).*

18. *Accordingly, there are good reasons for [Stephanie Patience]'s inability to attend:*

(a) *[PRIVATE];*

(b) *Her childcare issues. [Stephanie Patience]'s child is extremely young and, given her relocation, she has no childcare. It would not be appropriate for her to leave her child.*

19. *The NMC has also attempted to put forward alternatives to assist.*

<u>Notice</u>

20. *Both registrants were given notice of the NMC intention to rely on hearsay by email on 4 July 2025. Neither registrant has responded with an objection.*

21. *It is accepted that it was not made clear in those emails that the application would be in respect of [Stephanie Patience] and the police material. If the registrants had attended, they would have known about this from day one of the hearing.'*

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31(1) provides that, so far as it is *'fair and relevant'*, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

Stephanie Patience 's statement

The panel found Stephanie Patience's statement to be particularly relevant as it provides context to the standard of care provided by the registrants at the Home. The panel also considered that the statement includes specific evidence about individual residents, which is relevant to the alleged charges.

The panel noted that, although Stephanie Patience's statement is hearsay, it was made contemporaneously, in the course of her professional duties on behalf of a regulator and the statement is supported by other documentary records already in evidence. The panel considered that Stephanie Patience was acting under a duty to report accurately as part of her role, and therefore, there is no suggestion of any reason for her to fabricate evidence, or motive to conceal or misrepresent matters.

In considering fairness, the panel had particular regard to paragraphs 14 and 57 of Stephanie Patience's statement. Regarding paragraph 14, the panel noted this contains double hearsay as it relies on an earlier inspector's report. However, it acknowledged that all inspections and any subsequent reports were completed in a regulatory context, including Stephanie Patience's, which supports the general reliability of her statement.

Regarding paragraph 57, the panel considered this to be prejudicial as it largely consisted of Stephanie Patience's personal reflections, rather than direct factual observations. However, the panel was of the view that this does not justify excluding the entirety of the statement, but acknowledged that aspects should be treated with caution.

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

Further, the panel recognised that the NMC had made reasonable efforts to secure Stephanie Patience's attendance but she could not attend due to [PRIVATE]. The panel accepted that Stephanie Patience had a valid reason for non-attendance, which was supported by medical evidence.

The panel noted that as Mrs Cooper had been provided with a copy of Stephanie Patience's statement and, as Mrs Cooper had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Stephanie Patience and the opportunity of questioning and probing that testimony.

The panel also noted that no specific objection to the statement's admission was raised by Mrs Cooper. At the time the statement was made, she had an opportunity to respond but did not do so. The panel also considered that the NMC previously notified the registrants of the intention to adduce hearsay evidence on 4 July 2025.

Further, during the course of this application, Mrs Cooper was notified about the application to specifically adduce Stephanie Patience's evidence and given the opportunity to respond. The panel had regard to Mrs Cooper's response on 31 July 2025:

> *"Thank you for contacting me. I have no clear memory of that awful day, it was almost 8 years ago. Nothing that I have to say is of any importance to any of you obviously, I've accepted that now; although I find it strange that there are exceptions made for people like [*Stephanie Patience*] as compared to the rest of us."*

In his application to admit hearsay evidence, Mr James conceded that Stephanie Patience's statement and the exhibits attached were the sole and determinative

evidence in respect of charges 7, 9, 11, 12 and 17. The panel therefore had regard to the criteria set out in *Thorneycroft.* The panel had previously determined the evidence to be relevant and fair having taken account of:

- The NMC had taken reasonable steps to secure Stephanie Patience's attendance and offered her various means and accommodations to facilitate her participation.
- Mrs Cooper had prior notice of Stephanie Patience's evidence.
- There were good reasons for Stephanie Patience's non-attendance.
- There was no reason to believe Stephanie Patience's evidence was fabricated or that she had any motive to conceal or misrepresent matters.
- Stephanie Patience's evidence was contemporaneous to the events and created a part of her duties on behalf of a regulator.

In view of the public protection concerns involved and the public interest in ensuring the issues being explored fully, the panel concluded that it is fair and just to admit Stephanie Patience's statement as hearsay evidence and that fairness to the NMC outweighs any unfairness to Mrs Cooper. The panel will attribute what weight it deems appropriate at the fact-finding stage. The panel also noted that parts of the statement, particularly paragraph 57 and paragraph 14, may attract less weight due to their nature. The panel will carefully assess the statement's probative value alongside all other evidence when making its findings of fact.

The panel then went on to consider the seriousness of the charges, particularly in relation to charges 7, 9, 11, 12 and 17, taking into account the impact which adverse findings might have on Mrs Cooper's nursing career. However, it concluded that admitting the evidence does not unfairly prejudice Mrs Cooper, as the underlying concerns would still stand on the basis of other evidence. The panel considered that excluding Stephanie Patience's evidence would risk undermining the completeness and integrity of the fact-finding process. There is also a public interest in ensuring robust public protection where there are serious concerns.

Balancing all these factors, the panel decided that it would be fair and appropriate to admit all of Stephanie Patience's evidence. The panel will take the nature and context of the evidence into account and will give it what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Police Evidence

The panel found that the police evidence was relevant, as it relates to issues concerning missing records and provides important context, including when certain records were completed and how they were maintained. It considered that this evidence goes directly to the standards of care provided and Mrs Cooper's conduct.

The panel considered the fairness of admitting this material as hearsay. The panel noted that there was no information before it to indicate that the NMC had contacted the officers to provide oral evidence at this hearing. It noted that Mrs Cooper had no reasonable opportunity to cross-examine the officers or to challenge how the information was obtained or recorded.

The panel also considered that this evidence was of a factual nature given in the form of witness statements which are subject to criminal sanction unless true to their knowledge, information and belief.

Balancing all these factors, the panel decided that it would be fair and appropriate to admit all of the police evidence. The panel will take the nature and context of the evidence into account and will give it what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application of special measures for Steven Abbott

The panel heard an application under Rule 23(1)(c) of the Rules made by Mr James, seeking the provision of special measures to support Steven Abbott in giving oral evidence. [PRIVATE]. Steven Abbott requested a number of reasonable adjustments, which the panel considered appropriate.

Mr James submitted that these adjustments are intended to facilitate the effective participation of Steven Abbott at this hearing and enable him to give his best evidence.

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

[PRIVATE].

Having carefully considered the application, the panel concluded that the requested measures for extra time were appropriate, reasonable and necessary to enable Steven Abbott to give his best evidence. Accordingly, the panel granted the application for special measures.

Decision and reasons on no case to answer

The panel, of its own volition, considered whether there remained a case to answer in respect of charges 7a, 7b(i), 7b(ii), 9a, 9b and 11b, pursuant to Rule 24(7) of the Rules. The panel invited Mr James to make submissions in respect of these charges.

The panel noted that the evidence supporting these charges was predominantly hearsay, relying on second-hand accounts such as statements from family members, and comments from other nurses. In some instances, this amounted to 'double hearsay'. The panel also raised, in relation to charge 11b, whether there was a clear breach of duty of care, such as whether a care plan would properly state which foods could increase bowel movements, and so whether this omission alone would constitute a failure.

In response, Mr James submitted that Lucy Botting's position was clear from her comments in the evidence matrix. He therefore confirmed that the NMC did not wish to make any further submissions in respect of charge 11b.

Regarding charges 7 and 9, Mr James acknowledged the panel's concerns about the reliance on hearsay and the absence of direct patient records. He confirmed that the

NMC had no further submissions to make in response to these points and stated that this was a matter for the panel's consideration.

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

Charges 7 and 9

The panel considered the hearsay evidence from Stephanie Patience, noting that her account in her witness statement was itself hearsay and also relied on information from residents' family members who were not present and did not provide statements. The panel therefore considered this to be double hearsay, and as such, tenuous in accordance with the ruling set out in *R v Galbraith* [1981] 1 WLR 1039. The panel determined that there was no realistic prospect of finding the facts of charges 7a, 7b(i), 7b(ii), 9a, and 9b proved. Accordingly, the panel concluded that there is no case to answer in respect of these charges.

Charge 11b

The panel considered Lucy Botting's evidence in relation to this charge, noting her comments, which stated:

> *"Not often a question asked for bowel continence purposes".*

The panel found that the evidence did not establish a clear duty for Mrs Cooper to ensure that Resident M's person-centred care plan specified which foods increased bowel movement frequency.

In the absence of a clear duty, the panel found there could be no finding of failure. Therefore, it determined that there was no realistic prospect of finding the facts of charge 11b proved and concluded that there is no case to answer in respect of this charge.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of the resuming hearing that Mrs Cooper was not in attendance and that the Notice of Hearing letter had been sent to Mrs Cooper's registered email address by secure email on 28 August 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Cooper's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Mrs Cooper

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

Mr Edenborough submitted that Mrs Cooper had not responded to the NMC following the notice of hearing being sent to her on 28 August 2025. He submitted that there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Mrs Cooper. In reaching this decision, the panel has considered the submissions of Mr Edenborough and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Cooper;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Six witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2017;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Cooper in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Cooper's decision to absent herself from the hearing; she had waived her rights to

attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Cooper. The panel will draw no adverse inference from Mrs Cooper's absence in its findings of fact.

The hearing resumed on 22 June 2026. Neither Ms Prettyman nor Ms Cooper were present or represented at the hearing.

Decision and reasons on points raised by the panel on 25 June 2026

On 25 June 2026, the panel took a break from in camera deliberations on the facts to allow the legal assessor to put some legal advice on the record, following some points having been raised.

The Chair outlined the following points and invited Ms Jones to make submissions in response, the first in relation to the charge schedules for both registrants.

The charges for Mrs Cooper are prefaced by the wording 'You, a registered nurse, but makes no reference to her role as a deputy manager of the Home.

Further, in relation to charge 13(iii), it is currently drafted in the conjunctive as opposed to there being an alternative as between dry skin and keratosis. It is apparent to the panel that there is an issue that's been sought to be addressed, which may be constrained by the drafting of the charge as it is currently drafted, and so the panel is considering proposing to insert '/or' after the word 'and', so it would read 'failed to ensure any or adequate treatment of dry skin and/or keratosis'.

The third point relates to some documentation before the panel, specifically the letter from the CQC dated 29 January 2018 with a number of appendices that set detailed findings from the CQC inspection on 30 October and 1 November 2017. The panel had

regard to the content of those appendices, but not the outcome from the consideration of those by the CQC.

Ms Jones submitted that the NMC do not object to the proposed amendments being made to the charges, or the approach that the panel are seeking to adopt with respect to the evidence. She submitted that the amendments to the charges as they are currently formulated better reflects the evidence and corrects what appears to be procedural errors in terms of the drafting of the charge.

In respect of the CQC reports, Ms Jones referred the panel to the NMC's Guidance at DMA-6, which sets out that the panel are to make their own decisions in respect of the findings of facts and to provide full reasons. She submitted that the NMC have no objections to what has been outlined by the panel.

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

The Chair informed Ms Jones that, in light of the legal advice in respect of the issue of fairness and given that neither of the registrants are present nor represented at the hearing, the panel will seek their views on the proposed amendments to the charges. This has been the panel's approach in relation to previous applications. However, the panel bore in mind the public interest in expeditious disposal of this hearing and so proposed to give the registrants a time limit of 24 hours within which to respond, after which the panel will then proceed to make a decision in terms of the amendment of charges.

On 26 June 2026, the hearing resumed in public session. The Chair informed Ms Jones that no response was received by either registrant to the proposed amendments raised by the panel on 25 June 2026.

The panel has therefore decided to amend the charges as follows:

In relation to Mrs Cooper:

*‘You, a registered nurse, **in your role as Deputy Manager of Lound Hall Care Home’***

The further amendment in relation to charge 13n(iii) is as follows:

*‘Failed to ensure any or adequate treatment of dry skin and/**or** keratosis’.*

The panel was of the view that such amendments were in the interests of justice. It considered that the amendments addressed what the panel considered to be drafting errors and did not alter the substance of the charges but were made to provide necessary clarity. The panel was satisfied that Mrs Cooper had been provided with the proposed amendments, but that no response had been received from Mrs Cooper. Therefore, the panel was satisfied that there would be no prejudice to Mrs Cooper and that the amendments would enable the panel to properly consider the allegations and no injustice would be caused to either party by the amendment being allowed. The panel was therefore satisfied that it was fair and appropriate to amend the charges to ensure clarity, accuracy and properly reflect the evidence before it.

Details of charge (as amended)

That you, a Registered Nurse, in your role as Deputy Manager of Lound Hall Care Home

1 In Relation to Resident A,

a) Failed adequately or at all to ensure that repositioning records were complete

b) Following broken skin being identified on or about 5 March 2017, failed to ensure that a wound care plan was put in place.

c) Following weight loss and a MUST score of 2 being identified on or about 26 March 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place

d) Following a wound being identified by about 2 April 2017, failed to ensure that a wound care plan was put in place

e) Following weight loss being identified by about 6 May 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place

f) Following a wound being identified on or about 30 May 2017, failed to ensure that a wound care plan was put in place

g) Following weight loss being identified by about 14 June 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place

h) Following 2 wounds being recorded on or about 22 June 2017, failed to ensure that a wound care plan was put in place

i) Following Resident A being placed on nutritional supplements on 14 July 2017, failed to ensure that any or an adequate dietetic or nutritional plan was put in place

j) Following broken skin being identified on or about 26 July 2017, failed to ensure that a wound care plan was put in place

k) Following weight loss being identified by about 28 July 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place

l) Following weight loss being identified by about 11 August 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place

n) On or before 1 November 2017, failed adequately or at all to ensure that

i) A pressure mattress was set to the correct weight

ii) Any or an up-to-date Wound Care Plan was in place in relation to one or more wounds

iii) A care plan to manage the risk of Resident A choking was in place

iv) Any or an up to date care plan to help Resident A attain a healthy weight was in place

v) Resident A's food intake was being monitored

vi) Preventative action was taken to ensure that Resident A's low weight did not lead to skin damage.

2 In relation to Resident B:

a) On or around 7 September 2017, failed to ensure that an assessment took place and/or a wound care plan was in place in relation to a wound on Resident B's left shin

b) Failed to ensure that Resident B care records included one or more of the following:

i) A personal emergency evacuation plan

ii) A behaviour and agitation plan

iii) A dementia and cognition plan

iv) A personal hygiene plan

v) A communication plan

vi) An continence care plan tailored for Resident B's urinary needs and/or constipation, and/or updated to remove reference to a catheter which Resident B no longer had

vii) A nutritional care plan

viii) A pressure ulcer plan

ix) A Waterlow risk assessment

x) Any or adequate MUST documentation

xi) A record of how bruising identified in June 2017 had happened

xii) A record of how bruising identified in August 2017 had happened

xiii) A care plan was in place for skin tears to Resident B's left and right shins identified in August 2017

c) On or before 1 November 2017, failed to ensure that

i) Resident B was turned 2-hourly and/or that 2-hourly turns were recorded

ii) A care plan was in place to ensure that staff fed Resident B safely

iii) A nutrition care plan and/or food intake monitoring was in place

3 In relation to Resident C:

a) Failed to ensure that there was a monthly weight chart in their clinical records

b) From 26 September 2017, following identification of inflammation around their catheter, failed to ensure there was a related wound management plan in place.

c) Following identification of a pressure sore on or about 5 December 2016 failed to ensure there was a wound assessment and or that a wound care plan was put in place.

d) Following application of a dressing to a pressure sore on or about 12 March 2017, failed to ensure:

i) It was identified whether or not this was the same pressure sore as that at 3 c) above

ii) That there was a wound assessment and/or a wound care plan was put in place

iii) That a body map was completed

e) On or about 4 August 2017, following identification of a burst blister, failed to ensure that there was a wound assessment and/or a wound care plan was in place

f) On or about 7 August 2017, following identification of two skin tears, failed to ensure that there was a wound assessment and/or a wound care plan was in place

g) On or before 1 November 2017, failed to ensure that their room was cleaned frequently

4 In relation to Resident D:

a) Failed to ensure that one or more fluid intake charts was fully completed

b) Failed to ensure one or more repositioning records were completed and/or placed with resident D's notes on or after 3 September 2017

c) On or before 1 November 2017, failed to ensure that:

i) A pressure area care plan was in place

ii) A wound care plan was in place for one or more wounds on Resident D's arms

5 In relation to Resident E, on or before 1 November 2017, failed to ensure that:

a) A care plan for a pressure sore was in place

b) Measures to prevent further skin breakdown were in place

6 In relation to Resident F:

a) On one or more occasions, failed to ensure it was clear whether Resident F had insufficient hydration or intake was not recorded

b) Having been requested to provide a pressure mat failed to ensure that a pressure mat was provided and/or that a pressure area care plan was in place

c) Failed to ensure assistance was given for Resident F to feed

d) On or before 1 November 2017, failed to ensure that:

i) Staff had checked Resident F's sacrum for a pressure sore since 20 September 2017

ii) Measures to prevent further skin breakdown were in place

iii) A fall care plan was in place

7 In relation to Resident G,

a) In October 2017, failed to ensure that new stocks of Gabapentin and Ranitidine were obtained before Resident G missed one or more doses

b) On or about 1 November 2017, failed to ensure that:

i) A care plan in place for a mental health condition requiring medication was in place

ii) Resident G received their prescribed medication and/or their MAR charts accurately recorded when medication was or was not administered

8 In relation to Resident I:

a) Failed to ensure that they had adequate fluid intake and/or that fluid intake was recorded correctly

b) Failed to ensure that a care plan for urinary tract infections was in place

9 In relation to Resident J:

a) Failed to ensure that new stocks of Quetiapine were obtained before Resident J missed one or more doses

b) Failed to ensure that a change of dose of quetiapine was implemented

10 In relation to Resident K:

a) Failed to ensure that one or more wounds was described in a wound assessment chart, and/or body mapped and/or photographed

b) In early 2017, following weight loss of approximately 10kg since admission, failed to ensure that referral to a dietician was made

11 In relation to Resident M, failed to ensure that their person-centred care plan:

a) Included food preferences

b) Stated which foods increased bowel movement frequency

c) Recorded preferences for washing, dressing, and personal care

12 In relation to Resident N, on or before 1 November 2017, failed to ensure that their care plan identified any need for support or equipment to eat, and/or that their eating preferences were being observed

13 In relation to Resident O:

a) Failed to ensure that they were weighed or weights were recorded on admission and/or prior to December 2015

b) Following a pressure mattress being put in place on or around 27 October 2015, failed to ensure that it was checked regularly to ensure it was working and at the correct setting, or that there were any or adequate records of such checks

c) Failed to ensure that a Resuscitation care plan dated 18 July 2015 was completed, and/or personalised, and/or signed by Resident O

d) Failed to ensure that a Socialisation care plan updated on 16 January 2016 was personalised and/or signed by resident O and/or corresponded to activity charts

e) Failed to ensure that any or adequate activity stimulation was provided and/or recorded for Resident O

f) Failed to ensure that one or more risk assessments carried out on or about 10 April 2017 was updated regularly

g) Failed adequately or at all to ensure that Abbey Pain Scale documentation for Resident O was completed daily

h) Failed to ensure that Resident O was weighed and/or weights were recorded between November 2016 and June 2017

i) Failed to ensure that an assessment of a wound to the right knee was undertaken and/or recorded prior to 20 July 2017

j) Failed to ensure that an assessment was undertaken and/or recorded for a sacral sore in 2017

k) Failed to ensure that body maps were undertaken with sufficient frequency to meet Resident O's care needs

l) Failed to ensure that wound care documentation for Resident O was sufficiently complete to make clear:
   i) When in and around August 2017 sacral/upper back pressure ulceration developed and/or deteriorated
   ii) What if any management of the pressure ulceration referred to at 13 d) i) above there was until 18 October 2017.

m) On identifying that Resident O was at risk of malnutrition, failed to escalate that risk to a GP

n) On or before 18 October 2017:
   i) Failed to ensure prompt identification and/or any or adequate treatment, and/or any or adequate escalation of one or more pressure ulcers and/or open wounds.
   ii) Following the identification of one or more grade 4 pressure ulcers, failed to ensure that the CQC was notified of Resident O's condition.

iii) Failed to ensure any or adequate treatment of dry skin and/or keratosis

iv) Failed to ensure that one or more cream application charts was completed

v) Failed to ensure that they were repositioned 2 hourly when required or that there were records of such turns.

vi) Failed to ensure that one or more fluid charts were completed adequately or at all

vii) Failed adequately or at all to ensure that fluid intake was reviewed and/or acted upon, and/or that such reviews or actions were recorded

viii) Following weight loss, failed to ensure that Resident O was referred to a dietician

14 In relation to Resident R, on or before 17 October 2017, failed to ensure that they had a skin condition care plan in place.

15 In relation to one or more Residents, requiring a pressure mattress, failed adequately or at all to ensure that there was a monthly audit to affirm that the mattress was at the correct setting for their weight and body mass index.

16 In relation to one or more Residents, failed adequately or at all to ensure that

call bells would be answered promptly and/or in under 20 minutes and/or 10 minutes.

17 On or about 27 October 2017, in an email to the CQC, made one or more of the following representations directly or indirectly, which were not accurate:

a) In total, 2 Residents had pressure sores

b) Adequate care planning was in place for the Residents with pressure sores

c) Pressure mattresses for Residents with pressure sores had been set correctly

d) You had ascertained the matters at charges 17 a)-c) above by carrying out checks yourself

18. One or more of your representations at charges 17 above was dishonest and/or lacked candour in that:

a) You were representing as accurate information which you knew was not or may not be accurate

b) You were representing that you had carried out checks which you had not carried out, and/or did not make clear that you had not carried out checks yourself

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

Background

On 15 November 2017, Mrs Cooper was referred to the NMC by the Care Quality Commission (CQC). The CQC had received a number of safeguarding concerns raised by various healthcare professionals regarding severe pressure sores suffered by Resident O, who had subsequently died on 28 October 2018. The CQC notified the police, and an investigation ensued.

Mrs Cooper had been employed by Lound Hall Care Home (the Home) as the deputy manager since October 2012.

The CQC contacted the Home on 27 October 2017 to confirm that all residents had been checked for pressure ulcers, that those at high risk had adequate care plans, and that all pressure-relieving mattresses had been checked to ensure the correct pressure levels for each resident. Mrs Cooper emailed the CQC on the same day, confirming that the bed settings were correct and that all relevant residents had suitable care plans. She stated that only two residents had pressure ulcers, which were being monitored by staff.

When the CQC conducted urgent unannounced inspections on 31 October and 1 November 2017, it transpired that this was incorrect; five residents were identified as having pressure ulcers, and none of the residents had care plans for pressure ulcer care. Where required, mattresses were not set at the correct pressure levels. It was alleged that Mrs Cooper told the inspector they had given inaccurate information due to being busy with other matters at the time.

During the inspections, the CQC identified widespread concerns about resident safety, including a lack of care plans for pressure sores, concerns about residents' nutrition, risks of choking, poor medication management, and delays in promptly responding to residents' needs by answering call bells.

The CQC had previously identified concerns at the Home in January 2017. Instead of improvements, there had been a significant deterioration in the quality of care people received. Consequently, the Home's CQC rating was moved from 'requires improvement' to 'inadequate' as a result of the October 2017 inspections.

The concerns in respect of Mrs Cooper specifically relate to her management and leadership of the Home as Deputy Manager, as well as the direct provision of care to residents, in the following areas:

- Pressure care/tissue viability
- Nutrition
- Risk management
- Care planning

- Auditing/ record keeping
- Medicines management

It was also alleged that Mrs Cooper gave the CQC misleading and inaccurate information about the number of residents suffering from pressure sores, that the residents had been checked, and that her conduct in this regard was dishonest.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr James, and Mr Edenborough on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Cooper.

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

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

- Lucy Botting: A Registered Nurse, instructed by the NMC to provide an expert opinion on the standards of care provided by Mrs Cooper;

- Rebecca Nunn: A General Practitioner involved in the care of the residents of the home at the relevant time;

- Steven Abbott: A Contracts and Service Development Officer at the Council, who attended visits to the Home at the material time;

- Elena Marin: A Continuing Health Care (CHC) Nurse …;

- Jayne Jode: A specialist Tissue Viability Nurse (TVN), who visited Resident O in October 2017.

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

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

Charge 1

Before making its decision on the facts for each charge and sub-charge, the panel first determined how it would consider a *'failure'*. The panel established that, when determining if there was a *'failure'*, it would need to consider whether Mrs Cooper had a duty to perform the task as specified in the sub-charge.

Duty in relation to Care Planning

As a significant number of sub-charges to charge 1 related to a *'failure'* relating to care planning, the panel decided that it would first consider whether Mrs Cooper had a duty as a registered nurse, in her role as a deputy manager of the Home, in relation to care planning. In making its decision, the panel considered Lucy Botting's report.

The panel also took into account Mrs Cooper's nursing responsibilities as set out in the *'Job Description Deputy Manager.'* The panel noted that this document outlines her *'Principal Responsibilities'* which listed the following:

> *'**Purpose of position:***
>
> *To take joint responsibility with the Registered Manager as the person-in-charge for the day to day running of the Lound Hall*
>
> ***Care of the Service User***
>
> *• To ensure that the emotional, spiritual, physical, mental and material needs of the*
> *service users are recognised, assessed and met.*
> *• …*
> *• To undertake assessments of need of each service user in conjunction with the service user, relevant professional agencies and where appropriate, the service user's family.*
> *• To oversee the production of care plans and conduct regular reviews of care plans*
> *monitoring care and best practice.*

The panel noted that Mrs Cooper explained in her statement to the NMC in her view she *'… was not directly involved with care.'*

However, the panel had regard to Mrs Cooper's job description, which stated that she had joint responsibility with the registered manager of the Home for the day-to-day running of the Home. The panel noted that there were inconsistencies in Mrs Cooper's position as reflected in the documentation she provided to the panel. She sometimes maintained that she was not involved with care planning in any way, but at other times maintained that she had a responsibility for care planning for CHC patients only. The panel also noted throughout the nursing care records that Mrs Cooper did provide direct

nursing care to a range of residents, as evidenced by her signature on those records. The panel also noted that the service development plan referenced in the evidence of Steven Abbott, in which Mrs Cooper is clearly identified as a member of staff with responsibility to *'ensure that each care plan receives a monthly or responsive review and set up a system that tracks and monitors this'*. This is inconsistent with Mrs Cooper's written statement that she was not directly involved in care provision. Despite her absence from this hearing, the panel noted that Mrs Cooper had provided a number of documents, which the panel has carefully considered in order to minimise any potential disadvantage to Mrs Cooper. The panel was satisfied, on the balance of probabilities, taking into account all of the documentary evidence before it, that Mrs Cooper had joint responsibility with the registered manager of the Home and considered the charges in that context.

In making its decision, the panel took into account Lucy Botting's report. Lucy Botting was an expert witness and independent of the parties. She gave oral evidence which was supported by her written report. Lucy Botting had access to all relevant documents and her evidence was cogent and consistent throughout.

In Lucy Botting's report, the panel noted that the *'NMC: Standards for Proficiency'* outlines the expectations of a registered nurse regarding *'Assessing needs and planning care'*, which states:

> *'Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social, and spiritual needs. They use information obtained during assessments to identify the priorities and requirements for person-centred and evidence-based nursing interventions and support. They work in partnership with people to develop person-centred care plans that take into account their circumstances, characteristics, and preferences.'*

The panel also noted within the standards of proficiency, a section titled *'Care Plans and Risk Assessments'*, which outlined:

'Care planning and the evaluation of care plans should be undertaken regularly by a health professional such as a registered nurse on an ongoing basis and in particular when an individual's needs change. Thus, a review and update of the care plan is critical on each occasion that care is undertaken i.e., for wound care this should be reviewed every time the wound is reviewed…'

The panel concluded that, having considered all of the evidence including Mrs Cooper's job description, it was satisfied that she had a duty and was responsible for care planning for all residents.

Duty in relation to weight management

The panel also noted that a number of sub-charges to charge 1 related to a *'failure'* relating to weight and nutritional management for residents in the Home. Therefore, the panel decided it would next consider whether Mrs Cooper had a duty as a registered nurse in her role as deputy manager in relation to weight and nutritional management for residents in the Home.

In making its decision as to whether Mrs Cooper had a duty, the panel had regard to Mrs Cooper's job description, which includes the responsibility of '…*ensuring that the dietary needs of service users are met'.*

The panel had regard to the CCG action plan, dated 9 November 2017, in which Mrs Cooper was a named person responsible for taking immediate action to *'conduct baseline assessment of the risk of each resident in the areas of nutritional intake, hydration, swallowing difficulties and risk of choking…'.*

The panel took into account Lucy Botting's evidence in which she identified that one of the standards of proficiencies for nurses is:

'Observing, assessing, and optimising nutrition and hydration status and determining the need for intervention and support. This includes the use

of a nutritional tool, assistance with feeding and drinking and the recording of fluid intake and output.'

Considering all of the evidence, the panel was satisfied that Mrs Cooper had a duty to meet the nutritional needs of all residents in the Home, therefore meaning that she had a duty to ensure the weight and nutritional management for all residents in the Home.

Charge 1a

'In Relation to Resident A,

a) Failed adequately or at all to ensure that repositioning records were complete.'

This charge is found proved.

Due to the wording of the charge being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that the repositioning records were complete. The panel was of the view that this duty goes back to the duty for care planning, as any repositioning requirement should have been recorded in the care plan for Resident A. In light of this, the panel was satisfied that Mrs Cooper had a duty as a registered nurse in her role as a deputy manager to ensure repositioning records were complete.

In light of establishing the duty, the panel went on to consider the evidence. The panel first took into account the oral evidence of Lucy Botting who explained to the panel that a repositioning record should be in place for 24 hours, seven days a week, and that for residents with pressure ulcers, repositioning should be done every two to four hours, depending on the individual and their care plan. Lucy Botting also told the panel that repositioning records should state the date and time, with the repositioning location clearly recorded. This should then be signed by the staff member who repositioned the resident.

The panel also took into account the email dated 31 October 2017 regarding the CQC's concerns, at paragraph 1.3, it is mentioned that *'Turn records did not evidence that [Resident A] had been repositioned regularly.'*

The panel considered Resident A's records, specifically their *'Attendance, Input and Output Chart'*, which contains no evidence that Resident A was turned or repositioned. The panel noted that a specific *'Turn Chart'* was only started on 11 September 2017, and the records had a number of blank pages as well as days with complete gaps. The panel were of the view that Resident A's records corroborated the CQC's concerns in the email dated 31 October 2017.

In light of the evidence above, the panel was satisfied that Mrs Cooper had failed to adequately ensure that Resident A's repositioning records were complete. Therefore, charge 1a is found proved.

Charge 1b, 1d, 1f, 1h, 1j, 1n(ii)

'In Relation to Resident A,

b) Following broken skin being identified on or about 5 March 2017, failed to ensure that a wound care plan was put in place.

d) Following a wound being identified by about 2 April 2017, failed to ensure that a wound care plan was put in place

f) Following a wound being identified on or about 30 May 2017, failed to ensure that a wound care plan was put in place

h) Following 2 wounds being recorded on or about 22 June 2017, failed to ensure that a wound care plan was put in place

j) Following broken skin being identified on or about 26 July 2017, failed to ensure that a wound care plan was put in place

n) On or before 1 November 2017, failed adequately or at all to ensure that

ii) Any or an up-to-date Wound Care Plan was in place in relation to one or more wounds'

These charges are found proved.

The panel decided to consider these charges together because they all required consideration of whether Mrs Cooper failed to ensure wound care plans were in place. Having already been satisfied that Mrs Cooper had a duty as a registered nurse in her role as deputy manager related to managing and ensuring care planning at the Home, the panel was satisfied that Mrs Cooper had a duty to ensure that wound care plans were in place.

The panel was satisfied that Mrs Cooper had a duty to ensure that wound care plans were in place once a wound, which includes pressure ulcers, had been identified. The panel then considered the evidence relating to these sub-charges.

The panel heard evidence from Elena Marin. Her oral evidence was consistent with her written statements and her exhibits. The panel took into account Elena Marin's police witness statement, where she stated:

'MUST is an assessment to establish if people are at risk of malnourishment and Waterlow it's to establish if people are at risk of developing pressure sores. These are both basic tools which should be followed up with a care plan to reflect what was highlighted by the assessment and what needs to be actioned in order to minimise the risk.'

The panel also considered the '*National Categorisation for Ulcers',* which outlines the NHS's pressure ulcer categorisation. It defines each wound type and when a wound care plan is needed.

The panel took into account the oral evidence of Lucy Botting. In summary, Lucy Botting explained that when a new wound or pressure ulcer is identified, creating a new individualised care plan is required. She told the panel that the care plan should be individualised to the wound and the Resident, and should include:

> *'… repositioning advice (i.e. repositioning every 2-4 hours), nutrition (increased protein), fluid support, pressure-relieving equipment to include off loading and tilt mechanics and the wound dressing and frequency required…'*

Lucy Botting also explained that a wound assessment chart should be in place. This chart should identify 'the wound', its measurements, the *'wound bed typology-slough, granulation, and/or grade of pressure ulcer'*. If there are multiple wounds, *'then the areas/wounds should be numbered so it is clear which wound is being dressed and whether there is improvement or deterioration.'* Lucy Botting advised the panel that a corresponding body map and photographs should be maintained, with these updated at every redressing or reassessment. Additionally, the staff member who assessed the wound should sign and date these records each time.

Lucy Botting further stated that the registered manager as well as the deputy manager of the home should scrutinise these care plans and wound assessments to keep them updated on the wound, noting any improvements or deterioration.

In light of the evidence set out above, the panel went on to consider each sub-charge separately, with respect to the specific facts of each sub-charge.

Charge 1b

In its consideration of this sub-charge, the panel took into account the report of Lucy Botting, specifically where she stated:

> *'On 5th March 2017 broken skin was documented to Resident A's right buttock by colleague 2. A dressing was applied. No wound care plan was put in place.'*

The panel also considered Resident A's records, specifically her *'Nursing Care Progress/Evaluation'*. The panel noted that the notes for 5 March 2017 corroborate what Lucy Botting stated in her report.

The panel carefully considered all of the evidence in relation to Resident A and could not identify any evidence to indicate that a wound care plan was in place.

In light of all of the evidence outlined above, the panel determined that on or about 5 March 2017, Mrs Cooper failed to ensure that a wound care plan was put in place for Resident A when a wound was identified. Therefore, the panel found charge 1b proved.

Charge 1d

In its consideration of this sub-charge, the panel took into account the report of Lucy Botting, specifically where she stated:

> *'On 2nd April 2017 it was noted by Colleague 2 that Resident A had a small wound on her lower right leg (shin area). This was redressed. No care plan/wound assessment was put in place.'*

The panel also considered Resident A's records, specifically her *'Nursing Care Progress/Evaluation'*. The panel noted that the notes for 2 April 2017 corroborate what Lucy Botting stated in her report, and there was no evidence before the panel to indicate that a wound care plan was in place.

In light of all of the evidence outlined above, the panel determined that on or about 2 April 2017, Mrs Cooper failed to ensure that a wound care plan was put in place. Therefore, the panel found charge 1d proved.

Charge 1f

In its consideration of this sub-charge, the panel took into account the report of Lucy Botting, specifically where she stated:

> *'On 30th May 2017 a skin tear noted to left leg by Colleague 3. No wound assessment was put in place.'*

The panel also considered Resident A's records, specifically her *'Nursing Care Progress/Evaluation'*. The panel noted that the notes for 30 May 2017 corroborate what Lucy Botting stated in her report, and there was no evidence before the panel to indicate that a wound care plan was in place.

In light of all of the evidence outlined above, the panel determined that on or about 30 May 2017, Mrs Cooper failed to ensure that a wound care plan was put in place. Therefore, the panel found charge 1f proved.

Charge 1h

In its consideration of this sub-charge, the panel took into account the report of Lucy Botting, specifically where she stated:

> *'On 22 June 2017 Two small broken areas were documented on Resident A's sacrum by Colleague 2. Repositioning was advised. No wound assessment or care plan was put in place.'*

The panel also considered Resident A's records, specifically her *'Nursing Care Progress/Evaluation'*. The panel noted that the notes for 22 June 2017 corroborate what

Lucy Botting stated in her report, and there was no evidence before the panel to indicate that a wound care plan had been put in place.

In light of all of the evidence outlined above, the panel determined that on or about 22 June 2017, Mrs Cooper failed to ensure that a wound care plan was put in place. Therefore, the panel found charge 1h proved.

Charge 1j

In its consideration of this sub-charge, the panel took into account the report of Lucy Botting, specifically where she stated:

> *'On 26th July 2017 an area of her inner buttock noted to be red. The skin was broken. 2 hourly turns were requested ... No care plan was put in place.'*

The panel also considered Resident A's records, specifically her *'Nursing Care Progress/Evaluation'*. The panel noted that the notes for 26 July 2017 corroborate what Lucy Botting stated in her report, and there was no evidence before the panel to indicate that a wound care plan was in place.

In light of all of the evidence outlined above, the panel determined that on or about 26 July 2017, Mrs Cooper failed to ensure that a wound care plan was put in place. Therefore, the panel found charge 1j proved.

Charge 1n(ii)

The panel took into account all of the evidence outlined in charges 1b, 1d, 1f, 1h, and 1j. It reviewed Lucy Botting's report, in which she identified evidence of numerous occasions upon which Mrs Cooper had not ensured that any or up to date wound care plans were put in place for Resident A.

In light of all of the evidence outlined above, the panel determined that on or before 1 November 2017, Mrs Cooper failed to adequately ensure that up-to-date wound care plans were in place in relation to one or more wounds for Resident A. Therefore, the panel found charge 1j proved.

Charge 1c, 1e, 1g, 1k, 1l

'In Relation to Resident A,

c) Following weight loss and a MUST score of 2 being identified on or about 26 March 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place.

e) Following weight loss being identified by about 6 May 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place

g) Following weight loss being identified by about 14 June 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place

k) Following weight loss being identified by about 28 July 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place

l) Following weight loss being identified by about 11 August 2017, failed to ensure that a dietetic referral was made and/or that a GP review took place'

These charges are found proved.

Due to the wording of the charges being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that either a dietic referral was made, and/or a GP review took place in relation to the individual charges.

The panel has already been satisfied that Mrs Cooper had a duty as registered nurse in her role as deputy manager related to weight management of Residents at the Home.

The panel took into account the evidence of Lucy Botting. Lucy Botting told the panel that a weight loss of over 10% should have led to an automatic referral to the GP and escalation to the Home manager. She explained that where a resident loses weight, so as to be identified as being at risk of malnutrition, there is a duty to escalate including a referral to the GP to complete the dietetic referral. Lucy Botting also explained that the Home's guidance on MUST scores states that a score of *'1'* indicates a medium malnutrition risk, requiring the staff to complete 3 days of dietary documentation, and potential management such as informing the GP or the dietitian, and providing snacks, meal encouragement, or a fortified diet. If the MUST score is *'2'* or higher, this indicates a high malnutrition risk, and the resident should be referred to a GP or dietitian.

The panel was therefore satisfied that Mrs Cooper had a duty to ensure that all residents had either a dietetic referral and/or a GP review following weight loss.

Having established that Mrs Cooper had this duty, the panel then considered the evidence relating to these sub-charges.

Charge 1c

When considering this sub-charge, the panel noted the weight chart for Resident A, which recorded that prior to admission she weighed 57.2kg, and on 26 March 2017, her weight has dropped to 48.7kg.

The panel also took into account the report of Lucy Botting, specifically where she stated:

'On 26 March 2017 Resident A was weighed by Colleague 3. She was 48.7kg and had lost a further 1.3kg. Her MUST was 2. No dietetic referral was made, no GP review took place.'

In Resident A's records, the panel noted that on her MUST score chart, for 26 March 2017, Resident A's score was recorded as *'2'*. The panel was of the view that this was corroborative of Lucy Botting's evidence.

The panel noted that Resident A's GP visit chart shows she was under GP review from 6 March 2017 for six weeks. Although it was noted that Resident A had lost weight by 26 March 2017, the panel found no evidence to demonstrate that the GP was asked to review Resident A's weight loss at this time. It also found no evidence of any GP review or referral to dietetics in Resident A's *'Nursing Care Progress/Evaluation'* notes.

In light of the evidence above, the panel determined that on or about 26 March 2017, Mrs Cooper failed to ensure that a dietetic referral was made and that a GP review took place following Resident A's weight loss and identified MUST score of *'2'*. Therefore, the panel found charge 1c proved.

Charge 1e

In its consideration of this sub-charge, the panel took into account the report of Lucy Botting, specifically where she stated:

'On 6th May 2017 Resident A was weighed by Colleague 3. She was 48.1kg. A loss of 2.7kg and total loss prior to her admission of 9.1kg. No referral to dietetics was made. No review by the GP was forthcoming.'

In Resident A's records, the panel noted that on her MUST score chart, on both 22 April 2017, and 22 May 2017, Resident A's score was recorded as *'2'*. Furthermore, the panel took into account Resident A's weight chart, where her weight was recorded as

'48.1kg' on 6 May 2017. The panel was of the view that this was corroborative of Lucy Botting's report and oral evidence.

The panel noted that Resident A's GP visit chart does not show evidence that the GP was asked to review Resident A's weight loss around 6 May 2017. It also found no evidence of any GP review or referral to dietetics in Resident A's *'Nursing Care Progress/Evaluation'* notes.

In light of the evidence above, the panel determined that by about 6 May 2017, Mrs Cooper failed to ensure that a dietetic referral was made and that a GP review took place following Resident A's weight loss being identified. Therefore, the panel found charge 1e proved.

Charge 1g

The panel was satisfied that Mrs Cooper had a duty to ensure that all residents had either a dietetic referral and/or a GP review following weight loss for the reasons already articulated by the panel in charge 1(c).

In its consideration of this sub-charge as to whether Mrs Cooper failed in her duty, the panel took into account the report of Lucy Botting, specifically where she stated:

> *'On 14th June 2017 Resident A was weighed by Colleague 1 she documented her weight at 47.3kg. A further decrease in weight. No dietetics referral was made. The GP was not informed.'*

In Resident A's records, the panel noted that on her MUST score chart, on 16 June 2017, Resident A's score was recorded as *'2'*. Furthermore, the panel considered Resident A's weight chart, where her weight was recorded as *'47.3kg'* on 14 June 2017. The panel was of the view that this was corroborative of Lucy Botting's report and oral evidence. The panel was therefore satisfied that Resident A's weight loss required a dietetic referral and/or a GP review.

The panel noted that Resident A's GP visit chart does not show evidence that the GP was asked to review Resident A's weight loss around 14 June 2017. It also found no evidence of any GP review or referral to dietetics in Resident A's *'Nursing Care Progress/Evaluation'* notes.

In light of the evidence above, the panel determined that about 14 June 2017, Mrs Cooper failed to ensure that a dietetic referral was made and that a GP review took place following Resident A's weight loss being identified. Therefore, the panel found charge 1g proved.

Charge 1k

The panel was satisfied that Mrs Cooper had a duty to ensure that all residents had either a dietetic referral and/or a GP review following weight loss for the reasons already articulated by the panel in charge 1(c).

In its consideration of this sub-charge as to whether Mrs Cooper failed in her duty, the panel took into account the report of Lucy Botting, specifically where she stated:

> *'On 28th July 2017 Resident A's weight reduced further. Colleague 3 weighed her. She was 43.3kg. A further loss of 4kg. No action was taken.'*

In Resident A's records, the panel noted that on her MUST score chart, on 11 July 2017, Resident A's score was recorded as *'2'*, and the risk level was categorised as *'high'*. Furthermore, the panel considered Resident A's weight chart, where her weight was recorded as *'43.3kg'* on 28 July 2017. The panel was of the view that this evidence is corroborative of Lucy Botting's report and oral evidence. The panel was therefore satisfied that Resident A's weight loss required a dietetic referral and/or GP review.

The panel had sight of a note on Resident A's records from Colleague 1, dated 11 July 2017, which states:

'Resident A is identified as high risk of malnutrition due to her BMI being 18. Intake is documented. Resident A has been added to GP list 12/07 for referral to dietician.'

In Resident A's nursing care progress/evaluation record, a GP review on 12 July 2017 is noted; however, there is no mention of a referral to the dietician, nor was there mention of her weight loss. The panel carefully considered all of the evidence in relation to Resident A and found nothing to support a dietetic referral being made or GP review being requested relative to weight loss.

In light of the evidence above, the panel determined that by about 28 July 2017, Mrs Cooper failed to ensure that a dietetic referral was made. The panel did note that a GP review took place on 12 July 2017, but it did not have evidence that this review was in respect of Resident A's weight loss. Therefore, the panel found charge 1k proved.

Charge 1l

The panel was satisfied that Mrs Cooper had a duty to ensure that all residents had either a dietetic referral and/or a GP review following weight loss for the reasons already articulated by the panel in charge 1(c).

In consideration of this sub-charge as to whether Mrs Cooper failed in her duty, the panel noted that in Resident A's records, on her MUST score chart, on 11 August 2017, Resident A's score was recorded as *'2'*.

The panel also considered Resident A's weight chart, where her weight was recorded as *'45.7kg'* on 5 August 2017, but *'43.6kg'* on 11 August 2017. In light of this fluctuation of Resident A's weight, the panel considered Lucy Botting's oral evidence. Lucy Botting had explained that although there is a fluctuation in Resident A's weight, overall, there is a significant downward trend, and Resident A's weight was significantly lower than it should have been. The panel accepted Lucy Botting's evidence and was therefore satisfied that Resident A's weight loss required a dietetic referral and/or GP review.

The panel took into account Resident A's *'Nursing Care Progress/Evaluation'* notes. It noted an entry on 11 August 2017 stating that Resident A's daughter requested a GP visit. On 23 August 2017, a GP visit is documented; however, Resident A's weight loss is not mentioned. The panel reviewed Resident A's GP visit chart and noted that there was no mention that the GP was informed of Resident A's weight loss or that any referral relating to Resident A's weight loss was made.

In light of the evidence above, on the balance of probabilities, the panel determined that by about 11 August 2017, Mrs Cooper failed to ensure that a dietetic referral was made and/or that a GP review took place following Resident A's weight loss being identified. Therefore, the panel found charge 1l proved.

Charge 1i

'In Relation to Resident A,

i) Following Resident A being placed on nutritional supplements on 14 July 2017, failed to ensure that any or an adequate dietetic or nutritional plan was put in place.'

This charge is found proved.

Due to the wording of the charge being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that any, or an adequate dietetic or nutritional plan was put in place.

It was of the view that this duty goes back to the duty for care planning, and to the duty to ensure the weight and nutritional management of residents in the Home. Having already determined that Mrs Cooper had a duty in relation to both, the panel was satisfied that Mrs Cooper had a duty as a registered nurse in her role as a deputy manager to ensure that any or any adequate dietetic or nutritional plan was put in place for Resident A when she was placed on nutritional supplements.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel first took into account Resident A's records, namely the nursing care progress/evaluation notes. The panel noted the entry on 14 July 2017 which stated that she *'commenced on Fresubin',* a fortified supplement, on that day.

It then considered the evidence of Lucy Botting. Lucy Botting explained that a new nutritional care plan should have been put in place to make it clear that Resident A was on fortified supplements, and her weight should have been monitored weekly to observe for any response to these fortified supplements. The panel was therefore satisfied that Resident A had been placed on nutritional supplements which should have been included in a care plan.

The panel then took into account Resident A's records, specifically her care plan, dated 19 February 2017. This identified Resident A's care needs in relation to *'nutrition and hydration'*. It identified that Resident A's MUST score was *'2'* and that it should be assessed *'monthly'.* The panel noted that although the care plan had acknowledged Resident A's MUST score, it did not include anything regarding the interventions staff should take to manage her nutrition. The panel was of the view that although there is a care plan in place, it was unsatisfactory in that it provided no information about how staff would get Resident A to eat to maintain her weight, nor did it mention how staff should fortify her food. Furthermore, the panel noted that there was no evidence before it to show that the care plan was updated to reflect the nutritional supplements commenced on 14 July 2017.

The panel also considered the email to the CCG dated 31 October 2017, regarding the CQC's concerns about Resident A, which stated:

> *'Weight has reduced from 57KG in February to 36KG in October but no nutrition care plan in place. Not clear what action has been taken as a result of weight loss.'*

The panel considered that this corroborated the evidence from Resident A's records and Lucy Botting's oral evidence.

In light of the evidence above, the panel determined that following Resident A being placed on fortified supplements on/or about 14 July 2017, Mrs Cooper failed to ensure that an adequate dietetic or nutritional plan was put in place. Therefore, the panel found charge 1i proved.

Charge 1n(i)

'In Relation to Resident A,

n) On or before 1 November 2017, failed adequately or at all to ensure that

i) A pressure mattress was set to the correct weight.'

This charge is found proved.

Due to the wording of the charge being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that Resident A's pressure mattress was set to the correct weight. The panel was of the view that the duty in this charge directly related to the duty as a registered nurse in her role as a deputy manager for care planning.

The panel took into account of the witness statement from Jayne Jode, who was a tissue viability nurse. She explained:

'Dynamic mattresses are used with residents that are at a high risk of pressure ulcers. A dynamic mattress is an electric pressure relieving mattress. It has air cells and an electric pump which works when air is changed in the cells over a period which reduces the pressure. There are different models and makes on the market. The mattress chosen should meet the patient risk assessment as a patient at high to very high risk and unable to move independently will require a dynamic mattress to assist in reducing the risk.'

The panel was of the view that Jayne Jode, who was a specialist TVN was clear and consistent in her evidence, which was supported by documentary evidence before the panel.

The panel also considered Lucy Botting's oral evidence. Lucy Botting told the panel that if a resident was lighter than the mattress, it would be ineffective, detrimental to pressure areas, and could cause further pressure injury or damage. Lucy Botting also explained that the pressure mattresses should be adjusted monthly after weighing the resident, which should be clearly documented in the resident's care plan.

In light of this, the panel was satisfied that Mrs Cooper had a duty to ensure that Resident A's pressure mattress was set to the correct weight.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel went on to consider Resident A's records, namely her care plan, dated 19 February 2017. This identified Resident A's care needs in relation to *'Pressure area care/waterlow'*. The panel noted that although this care plan identified the need for Resident A to have a pressure mattress, it did not provide staff with any information on making changes to the settings following any weight changes.

The panel also took account of the email from the CQC to the CCG dated 1 November 2017 which stated the following:

> *'1.3 Resident A has a grade 3 pressure ulcer to her heel and reddening to her sacrum. We found that her pressure mattress setting was incorrect for her weight, despite being assured these had all been checked on Friday…'*

In light of the evidence above, the panel was satisfied that Resident A's mattress was not set to the correct weight. The panel therefore determined that on or before 1 November 2017, Mrs Cooper failed to adequately ensure that Resident A's pressure mattress was set to the correct weight. Therefore, the panel found charge 1n(i) proved.

Charge 1n(iii)

'In Relation to Resident A,

n) On or before 1 November 2017, failed adequately or at all to ensure that

iii) A care plan to manage the risk of Resident A choking was in place'

This charge is found proved.

Due to the wording of the charge being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that a care plan was in place to manage the risk of Resident A choking.

The panel was of the view that the duty in this charge was directly related to the duty Mrs Cooper had as a registered nurse in her role as deputy manager for care planning for the reasons articulated earlier by the panel in charge 1. The panel took account of Mrs Cooper's job description, which sets out her responsibility to ensure that the needs of service users are assessed and met. The panel, having carefully considered all of the evidence, was satisfied that Mrs Cooper had a duty to ensure that a care plan was in place for any resident at risk of choking.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel considered Resident A's records, which included a one-page log with a handwritten title of 'Dysphagia' and three entries dated 11 July 2017, 12 August 2017, and 11 September 2017. The panel noted that the notes mention Resident A remaining 'high risk of dysphagia' in July 2017. The panel was therefore satisfied that Resident A was at risk of choking.

However, the panel noted that no care plan is referenced and there is no evidence that a care plan was created. It was of the view that as Resident A was considered high risk, a care plan should have been in place to meet Resident A's needs.

The panel also took into account the evidence of Stephanie Patience, who, in her witness statement, explained that *'Resident A was noted to be at risk of choking but there was no care plan in place to manage this risk.'* Although the evidence of Stephanie Patience was admitted as hearsay, the panel took into account that it came from a reliable source in that Stephanie Patience was an inspector with the CQC. Her statement corroborated the other evidence which the panel had assessed and accepted as reliable. Consequently, the panel accorded it due weight.

In light of the evidence above, the panel determined that on or before 1 November 2017, Mrs Cooper failed to adequately ensure that a care plan was in place to manage the risk of Resident A choking. Therefore, the panel found charge 1n(iii) proved.

Charge 1n(iv)

'In Relation to Resident A,

n) On or before 1 November 2017, failed adequately or at all to ensure that

iv) Any or an up to date care plan to help Resident A attain a healthy weight was in place'

This charge is found proved.

Due to the wording of the charge being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that any or an up-to-date care plan was in place to help Resident A attain a healthy weight.

The panel was of the view that the duty in this charge was directly related to the duty for care planning as set out in the panel's findings articulated earlier in charge 1. It also considered that the duty in this charge is linked to Mrs Cooper's duty to ensure the weight and nutritional management of residents at the Home as previously articulated. In light of this, the panel was satisfied that Mrs Cooper had a duty to ensure that 'any or an up-to-date' care plan was in place for any resident who needed help to attain a healthy weight.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel took account of its findings in charges 1(c),1(e),1(g),1(k),1(i) and 1(l) and was satisfied that Resident A had been losing weight over a period of time and had been prescribed fortified supplements. The panel was therefore satisfied that Resident A required a care plan to assist them to attain a healthy weight.

The panel took into account Resident A's records, specifically her care plan, dated 19 February 2017. This identified Resident A's care need as *'weight management'*. The panel noted that Resident A's records only contained one weight management care plan, which was never updated to reflect her prescribed supplements from July 2017. The other care plans within Resident A's records that were relevant to attaining a healthy weight included a care plan for '*Diabetes'* dated 16 June 2017, and a care plan for *'Nutrition and hydration'*, dated 19 February 2019. The panel noted that these care plans were not updated to reflect Resident A's weight loss or prescribed supplements or made any reference to how Resident A could attain a healthy weight.

The panel also took into account the witness statement of Stephanie Patience, in which she states that:

> *'We noted that weight records for Resident A… showed they had lost 15.4kg between February and October 2017, but there was no care plan in place to help them attain a healthy weight.'*

Although Stephanie Patience's evidence was admitted as hearsay, for reasons given earlier, the panel gave it due weight.

In light of the evidence above, the panel determined that on or before 1 November 2017, there was a care plan in place to help Resident A attain a healthy weight, but Mrs Cooper had failed to ensure that it was up to date. Therefore, the panel found charge 1n(iv) proved.

Charge 1n(v)

'In Relation to Resident A,

m) On or before 1 November 2017, failed adequately or at all to ensure that

v) Resident A's food intake was being monitored.'

This charge is found proved.

Due to the wording of the charge being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that Resident A's food intake was being monitored.

For the reasons already articulated earlier in charge 1, the panel was of the view that the duty in this charge was directly related to the duty for care planning as a registered nurse in her role as deputy manager. It also considered that the duty in this charge is also linked to Mrs Cooper's duty to ensure nutritional management of residents in the Home. In light of this, the panel was satisfied that Mrs Cooper had a duty to ensure that all residents food intake was being monitored.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel considered Resident A's records, specifically the *'nursing care progress/evaluation'*. It noted that on 24 September 2017, there is a record which noted that Resident A was 'eating and drinking well.' However, the panel was unable to find any consistent references to Resident A's food intake beyond this.

The panel also reviewed Resident A's *'supplementary feeds record,'* which covered the period between 25 October 2017 and 10 November 2017. The panel noted that only the

lunch column had been completed, and the chart had been started a significant amount of time after Resident A was prescribed Fresubin in July 2017.

The panel noted that there is a log dated 11 July 2017, with a handwritten title of *'MUST'* which detailed that Resident A's *'intake is documented.'* However, the panel was unable to identify a clear and consistent record that documented intake.

In light of Resident A's records, the panel was of the view that although there are some records which monitored Resident A's food intake, there is not enough consistent evidence to support that adequate monitoring had taken place.

The panel also took into account Stephanie Patience's statement, which stated:

> *'… Their food intake was also not being monitored and so staff would be unaware of any other reasons for why they were not gaining weight…'*

Although the evidence of Stephanie Patience was admitted as hearsay, for reasons already given, the panel accorded it due weight.

In light of the evidence above, the panel determined that on or before 1 November 2017, Mrs Cooper failed to adequately ensure that Resident A's food intake was being monitored. Therefore, the panel found charge 1n(v) proved.

Charge 1n(vi)

'In Relation to Resident A,

n) On or before 1 November 2017, failed adequately or at all to ensure that

vi) Preventative action was taken to ensure that Resident A's low weight did not lead to skin damage.'

This charge is found proved.

Due to the wording of the charge being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that preventative action was taken to ensure that Resident A's low weight did not lead to skin damage.

For reasons already articulated earlier, the panel was of the view that the duty in this charge was directly related to the duty as a registered nurse in her role as deputy manager for care planning. For the reasons set out earlier in charge 1, the panel was satisfied that Mrs Cooper had a duty in terms of management of weight and skin integrity to ensure that preventative action was taken to ensure that low weight did not lead to skin damage for any resident in the Home.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel also considered the email from the CQC to the CCG outlining their concerns on 31 October 2017. This corroborates the evidence mentioned above in the CQC letter, along with a further reference which states that *'Turn records did not evidence that Resident A had been repositioned regularly and there was no care planning advising staff on how to support Resident A with skin integrity.'*

Furthermore, the panel noted that a TVN referral had been requested for Resident A, but the panel considered Lucy Botting's evidence that this alone was not adequate preventative action.

The panel also took account of Stephanie Patience's statement:

> *'We noted that weight records for Resident A (see Exhibit SPH32) showed they had lost 15.4kg between February and October 2017, but there was no care plan in place to help them attain a healthy weight. Their food intake was also not being monitored and so staff would be unaware of any other reasons for why they were not gaining weight. Inadequate nutrition also impacts on skin integrity and there was no*

preventative action to ensure Resident A's low weight did not lead to skin damage.'

Although the evidence of Stephanie Patience was admitted as hearsay, the panel, for reasons already given, accorded it due weight.

In light of the evidence above, the panel was satisfied that Resident A had weight loss which required preventative action to ensure that it did not lead to skin damage. The panel determined that on or before 1 November 2017, Mrs Cooper failed to adequately ensure that preventative action was taken to ensure that Resident A's low weight did not lead to skin damage. Therefore, the panel found charge 1n(vi) proved.

Charge 2a

In relation to Resident B:

a) On or around 7 September 2017, failed to ensure that an assessment took place and/or a wound care plan was in place in relation to a wound on Resident B's left shin

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to ensure that care planning was carried out, properly recorded and included in residents' clinical records, the reasons for which are already articulated in charge 1. The duty to assess and plan for wounds has previously been articulated in the panel's findings in respect of charges 1d, 1f, 1h, 1i and 1n(ii). The panel was therefore satisfied that Mrs Cooper had a duty to ensure assessment and care plans were in place for any residents with a wound.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel considered Lucy Botting's report, which provided detail that Resident B had a wound on the bottom of their left shin on 7 September 2017, but that there was no associated wound care plan or assessment:

'On 7 September 2017 a dressing was changed to Resident B left bottom shin. Colleague 3 suggested observing for the next 24 hours as a further dressing may be required. Colleague 2 replaced this on the 8 September 2017. There is no associated wound care plan or assessment.'

Lucy Botting's evidence was corroborated by Resident B's nursing care progress notes dated 7 September 2017, which clearly identified the wound on the left shin.

The panel was unable to find any wound care assessment or wound care plan for Resident B's left shin wound. Therefore, the panel find this charge proved.

Charge 2b(i)

In relation to Resident B

b) Failed to ensure that Resident B care records included one or more of the following:

i) A personal emergency evacuation plan

This charge is found PROVED.

In deciding whether Mrs Cooper had a duty to ensure a personal emergency evacuation plan (PEEP) was in place, the panel considered Mrs Cooper's job description for the role Deputy Manager, in particular:

'Premises

• *…*

• *To ensure that Fire regulations are complied with and to undertake regular risk assessments of health and safety.*

• *To ensure that legislation and regulations concerning Environmental Health,*

Infection Control and Health and Safety are complied with and to advise the Board of Directors if action is required.

- *…'*

The panel considered that Mrs Cooper's job description provides a clear duty for compliance with legislation and fire regulations, which would have included a PEEP for all relevant residents. The panel was satisfied that Mrs Cooper had a duty as a registered nurse in her role as deputy manager to ensure PEEPs were in place for all residents who required them.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel had sight of a copy of the CQC email to the CCG regarding safeguarding concerns dated 31 October 2017, where Resident B is described as having been *'looked after in bed, no verbal communication and has advanced dementia.'* The panel also took into account Resident B's socialisation/activities care plan dated 19 November 2016, which states that *'due to Resident B poor health she is nursed in bed.'* The panel was satisfied on the balance of probabilities that Resident B was not mobile, would need assistance with evacuation, and a PEEP would therefore be required.

The panel also took into account Lucy Botting's evidence in relation to Resident B, specifically:

'The Personal Emergency Evacuation Plan (PEEP) appears to be missing...'

The panel was satisfied that there was no PEEP in place for Resident B.

The panel, for reasons already given, was satisfied that Lucy Botting was a reliable witness. It therefore determined that Mrs Cooper had failed in her duty to ensure that Resident B's care records included a PEEP. The panel therefore find charge 2b(i) proved.

Charges 2b(ii) and 2b(iii)

ii) A behaviour and agitation plan

iii) A dementia and cognition plan

These charges are found PROVED.

The panel decided to consider these two sub-charges together as they are inextricably linked.

The panel found there was a duty for Mrs Cooper to carry out care planning, the reasons for which are already articulated in charge 1.

The panel also took account of Mrs Cooper's job description, which sets out her responsibility to ensure that the needs of service users are assessed and met. In light of this, the panel was satisfied that Mrs Cooper had a duty to ensure that a care plan was in place for any resident who required support with behaviour, agitation, dementia and cognition.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of a copy of the CQC email to the CCG dated 31 October 2017, where Resident B is described as:

> *'looked after in bed, no verbal communication and has advanced dementia. No care plans in place to instruct staff on how to care for her…'*

The panel also took into account Lucy Botting's evidence, which is consistent with the CQC email correspondence, and includes a chronology covering the time between 3 February 2016 and 25 October 2017, providing several occasions on which Resident B was seen by the GP specifically for agitation.

The panel also had sight of a behaviour record chart dated 10 and 11 July 2017, which covers Resident B's agitated behaviour at the time. The panel was of the view that this

evidence is corroborated by Lucy Botting's report that there was a clear need for a behaviour and agitation plan.

Similarly, the panel also noted the evidence it had before it in relation to a need for a dementia and cognition plan for Resident B. The panel had sight of Lucy Botting's report, where it is noted that Resident B has *'advanced dementia, frailty and was unable to verbally communicate effectively'*. The panel found that this is corroborated by the CQC email to the CCG regarding safeguarding concerns dated 31 October 2017, which explicitly states that Resident B '*has advanced dementia.*' The panel also noted that the nursing admission sheet dated 30 January 2016 makes reference to Resident B having possible dementia on admission.

The panel was therefore satisfied that Resident B required care plans for behaviour, agitation, dementia and cognition.

The panel also noted that Lucy Botting's evidence does not mention a dementia and cognition care plan, and the documentary evidence before the panel did not include any such care plan. The panel further noted that Lucy Botting's evidence was that she could not locate a behaviour and agitation plan for Resident B in the records made available by the Home. The panel also found that it has no evidence before it to indicate that there was a behaviour and agitation plan for Resident B.

Taking all of this cogent evidence into account, the panel found that Mrs Cooper had failed to ensure that Resident B's records included a behaviour and agitation plan and also a dementia and cognition plan. The panel therefore finds charges 2b(ii) and 2b(iii) proved.

Charge 2b(iv)

iv) A personal hygiene plan

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to carry out care planning, the reasons for which are already articulated in charge 1.

The panel also took account of Mrs Cooper's job description, which sets out her responsibility to ensure that the needs of service users are assessed and met. In light of this, the panel was satisfied that Mrs Cooper had a duty to ensure that a care plan was in place for any resident who required assistance with personal hygiene.

In reaching this decision as to whether Mrs Cooper had failed in her duty, the panel took into account Lucy Botting's evidence, in particular:

> *'Resident B was doubly incontinent and required the assistance of two staff for all her activities of daily living'*

The panel had sight of a copy of the CQC email to the CCG regarding safeguarding concerns dated 31 October 2017, where Resident B is described as being *'looked after in bed',* which provides supporting evidence that Resident B is not very mobile and not able to independently undertake tasks of daily living.

The panel had sight of nursing input and output charts relevant to Resident B dated from 19 September 2016 onwards which mention changing of pads, checking, washing and many references to assisted washing and pad changes. The panel considered that this demonstrated that significant care was being given to support Resident B with their personal hygiene needs.

The panel also had sight of an email from the Home Manager dated 26 June 2017 giving staff directions in relation to washing Resident B.

The panel was therefore satisfied that Resident B required a personal hygiene care plan.

The panel took into account that Lucy Botting's evidence does not list a personal hygiene plan for Resident B and she stated in oral evidence that she had not seen such a plan. The panel found no plan in any of the evidence before it.

In light of all the evidence before it, the panel was satisfied that Mrs Cooper had failed to ensure that Resident B's care records included a personal hygiene plan. The panel therefore find this charge proved.

Charge 2b(v)

v) A communication plan

This Charge is found PROVED.

The panel found there was a duty for Mrs Cooper to carry out care planning, the reasons for which are already articulated in charge 1.

The panel also took account of Mrs Cooper's job description, which sets out her responsibility to ensure that the needs of service users are assessed and met. In light of this, the panel was satisfied that Mrs Cooper had a duty to ensure that a care plan was in place for any resident who required support with communication.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of a copy of the CQC email to the CCG regarding safeguarding concerns dated 31 October 2017, where Resident B is described as:

'looked after in bed, no verbal communication and has advanced dementia.'

The panel also took into account Lucy Botting's evidence, which provided a similar description of Resident B and corroborates what is set out in the CQC email correspondence:

'[Resident B] has advanced dementia, frailty and was unable to verbally communicate effectively.'

The panel was therefore satisfied that Resident B required a communication plan.

The panel noted that Lucy Botting in her evidence does not list any communication plan as part of the plans that are in place for Resident B's care. The panel also noted that there is no communication plan included in the evidence before it.

In light of all the evidence before it, the panel was satisfied that Mrs Cooper had failed to ensure that Resident B's care records included a communication plan, and therefore find this charge proved.

Charge 2b(vi)

vi) An continence care plan tailored for Resident B's urinary needs and/or constipation, and/or updated to remove reference to a catheter which Resident B no longer had

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to carry out care planning, the reasons for which are already articulated in charge 1.

The panel also took account of Mrs Cooper's job description, which sets out her responsibility to ensure that the needs of service users are assessed and met. In light of this, the panel was satisfied that Mrs Cooper had a duty to ensure that a care plan was in place for any resident who required support with urinary needs, constipation or catheterisation.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel took into account the following from Lucy Botting's evidence:

> *'Resident B was doubly incontinent and required the assistance of two staff for all her activities of daily living'*

In addition, the panel also had sight of input and output charts dated from 16 September 2016, which show that staff were routinely assisting Resident B to change pads.

The panel had sight of a catheter history commencing 12 January 2016 for Resident B, which stops on 2 June 2016. The evidence before the panel shows that Resident B appeared to pull out the catheter frequently.

The panel noted the CQC email correspondence to the CCG that Resident B is described as being *'looked after in bed'.*

The panel was satisfied based on evidence that Resident B was looked after in bed and that, as a consequence, they would have needed to have their bowel movements monitored to prevent constipation.

Therefore, the panel was satisfied that a continence care plan tailored for Resident B's urinary needs and/or constipation and/or catheter needed to be in place and that plan should be updated.

The panel considered that Lucy Botting's evidence states *'Equally care plans were not tailored to need for instance, the continence care plan is not tailored to her urinary needs (mentions a catheter which she no longer had) and did not include constipation.'*

The panel notes evidence that Resident B's catheter was removed, but this was not reflected in any documentary evidence before the panel.

Taking all of this evidence into account, the panel found this charge proved in its entirety.

Charge 2b(vii)

vii) A nutritional care plan

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to carry out care planning, the reasons for which are already articulated in charge 1. The panel has also found that there is a duty to manage residents' nutrition as articulated in its decision on charges 1(i), 1n(iv) and 1n(v).

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel took into account the following from Lucy Botting's evidence:

> *'Resident B was on a liquid diet and required assistance with all meals. She was documented as having a low appetite…*
>
> *Dr… referred Resident B to the dietician on the 12th September 2017*
>
> *On 10 October 2017 Resident B was seen by the dietician… Her current weight was noted to be 29.3kg… (morbidly underweight)… was noted to be at risk of malnutrition due to her extremely low body weight.*
>
> *The family had reported that Resident B suffered from many food intolerances and nausea and were extremely anxious about making changes to her diet…'*

The panel also had sight of various records corroborating Lucy Botting's evidence. This included references to Resident B being on Complan and nutritional supplements, which was recorded in a number of patient notes including Resident B's information chart and preadmission assessment. Resident B was referred to the Dietician on 14 September 2017. Resident B's weight charts throughout 2016 together with Resident B's nursing admissions sheet dated 30 January 2016 record that she was thin and dehydrated. Resident B's weight was noted to be 31 kg and later this had reduced to 29kg. There is also a record of a five-day food diary dated 18 October 2017.

The panel was therefore satisfied that a care plan would have been necessary given all of this evidence about Resident B's nutritional status.

The panel did not find any evidence of a nutritional care plan for Resident B, and Lucy Botting's evidence also did not refer to there being a nutritional care plan within the records provided by the Home.

Taking all of this credible evidence into account, the panel find this charge proved.

Charge 2b(viii)

viii) A pressure ulcer plan

This charge is found NOT proved.

The panel found there was a duty for Mrs Cooper to ensure that care planning was carried out, properly recorded and included in resident's clinical records, the reasons for which are already articulated in charge 1. The panel was also satisfied that Mrs Cooper had a duty in the management of skin integrity and wounds as set out in charge 1.

The panel considered evidence that a pressure ulcer plan was not required unless a pressure ulcer was identified.

The panel noted evidence that Resident B did not have a pressure ulcer, and in these circumstances, was not satisfied that a pressure ulcer care plan was required. Therefore, Mrs Cooper did not have a duty to ensure that Resident B's care records included a pressure ulcer care plan. This charge is therefore found not proved.

Charge 2b(ix)

ix) A Waterlow risk assessment

This charge is found PROVED.

The panel found that there was a duty on Mrs Cooper to undertake risk assessments. In reaching this decision, the panel had regard to Mrs Cooper's job description which sets out her responsibility to ensure that the needs of service users are assessed and met. The panel has already found that Mrs Cooper had a duty in respect of the management of skin integrity for all residents for reasons already articulated in charge 1. For this reason, the panel was satisfied that Mrs Cooper, in order to manage skin integrity, had a duty to ensure that all residents had a Waterlow risk assessment. The panel was therefore satisfied that Resident B required a Waterlow risk assessment.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel having considered all of the evidence before it, could not identify a Waterlow risk assessment for Resident B and therefore concluded that it was not included in Resident B's care records. The panel therefore find this charge proved.

Charge 2b(x)

x) Any or adequate MUST documentation

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to ensure that MUST assessments were carried out, properly recorded and included in all resident's care records, the reasons for which are already articulated in charge 1. The panel was therefore satisfied that Resident B should have MUST documentation completed in their care records.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel took into account Lucy Botting's evidence, which states the following as to Resident B's weight loss and MUST score:

> *'When Resident B was admitted to the Home she weighed 31.8kg… It was noted in the records on admissions that her MUST score was 2…*
>
> *…*

Whilst weight was recorded monthly and then two weekly from June 2016, and Resident B weight remained consistent, there is no evidence of monthly MUST assessments within the clinical records'

Elena Marin in her evidence stated that she was concerned about the record keeping at the Home, including its quality and accuracy, as she recalls seeing MUST scores calculated inaccurately.

Lucy Botting in her evidence states that MUST documentation appears to be missing from Resident B's care records. Although the panel found reference to Resident B's MUST scores in the nursing documentation, it could find no adequate MUST documentation in Resident B's records. Such records that were available to the panel were sporadic and only partially complete.

The panel therefore find this charge proved.

Charges 2b(xi) and 2b(xii)

xi) A record of how bruising identified in June 2017 had happened

xii) A record of how bruising identified in August 2017 had happened

These charges are found PROVED.

The panel considered these two sub-charges together given the commonality of the allegation.

The panel found that there was a duty on Mrs Cooper to ensure that records were in place for all residents who had bruising. In reaching this decision, the panel had regard to Mrs Cooper's job description which sets out her responsibility to ensure that the needs of service users are assessed and met. The panel has already found that Mrs

Cooper has a duty in respect of the management of skin integrity, including bruising, for all residents, for reasons already articulated in charge 1.

The panel also had regard to the evidence of Lucy Botting, which stated that she would expect an incident form to be completed on each occasion of bruising and for the bruising to be investigated as it is also a safeguarding matter.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel took account that Resident B's body map dated 13 June 2017 recorded bruising, but did not identify how it had happened. A further body map recorded slight bruising to the forearms on 10 August 2017 but again did not identify how it happened. The panel noted that these two body maps were also referred to in Lucy Botting's evidence, which states the following:

> *'The body map references that in June 2017 Resident B had:*
>
> *Slight bruising to her forearms and knees… no incident form within the evidence denotes how the bruising appears to have happened.*
>
> *This is the same in August 2017 where Resident B was noted to have 5 bruises: bruising to her right forearm, left arm (posterior) two bruised hands…'*

The panel was satisfied that Resident B had bruising, identified in June 2017 and August 2017, but there was no record of how it happened on either occasion.

Therefore, the panel found this charge proved.

Charge 2b(xiii)

xiii) A care plan was in place for skin tears to Resident B's left and right shins identified in August 2017

This charge is found PROVED.

The panel had already found there was a duty for Mrs Cooper to ensure that care planning was carried out, properly recorded and included in resident's clinical records, the reasons for which are already articulated in charge 1. The panel was also satisfied that Mrs Cooper had a duty in the management of skin integrity and wounds as set out in charge 1.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel took into account Lucy Botting's evidence, which sets out the following:

> *'… Resident B was noted to have … small tear to her left and right shins.*
>
> *There is also no care plan in place for her skin tear'*

Lucy Botting's evidence is corroborated by the body map dated 10 August 2017, and the nursing care and progress notes dated 7 and 8 October 2017 which reference skin tears to the Resident B's left bottom shin. The panel was therefore satisfied that Resident B had skin tears and required a care plan for these.

Having carefully considered the evidence, the panel was not satisfied that there was any evidence of a care plan in respect of the skin tears to Resident B's left and right shins identified in August 2017.

The panel therefore found this charge proved.

Charge 2c(i)

c) On or before 1 November 2017, failed to ensure that

i) Resident B was turned 2-hourly and/or that 2-hourly turns were recorded

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to ensure that turning took place for all residents as required, as articulated in its findings at charge 1a, and was properly recorded and included in resident's clinical records.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel took into account Lucy Botting's evidence in this regard. It considered that Lucy Botting's evidence was clear and cogent, and supported by documentary evidence, as to the need to turn Resident B, given that they were at a high risk of developing pressure ulcers. It was therefore satisfied that there was a requirement for Resident B to be turned 2 hourly and that there was a requirement for this turning to be recorded.

The panel noted that whilst some documentation did record 2 hourly turns, some of the records were inconsistent, incomplete and contained large periods of time when there was no documentation confirming or recording Resident B was turned on a 2 hourly basis.

The panel also heard oral evidence from Lucy Botting that whilst turns did take place, they were done in an inconsistent and irregular manner.

The panel considered this evidence to be reliable. It comes from a reliable source and is consistent with all evidence relating to this charge.

The panel was therefore satisfied that Mrs Cooper failed to ensure that Resident B was turned 2 hourly and/or that 2 hourly turns were recorded.

The panel accepted this consistent evidence and found this charge proved.

Charge 2c(ii)

ii) A care plan was in place to ensure that staff fed Resident B safely

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to carry out care planning, the reasons for which are already articulated in charge 1. The panel has also found that there was a duty to manage nutrition for all residents as articulated in its decision on charges 1i, 1n(iv) and 1n(v). The panel was therefore satisfied that Mrs Cooper had a duty to put a care plan in place to ensure that staff fed Resident B safely.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of a choking risk assessment dated 6 November 2017. The panel noted that this had been poorly completed, with *'never'* and *'more than once'* being selected for problem areas including coughing, choking, difficulty eating, unplanned weigh loss etc. None of the problem areas on the risk assessment had been ticked 'often' or 'always'. However, the panel noted that Resident B, according to Lucy Botting's evidence, was at a high risk of choking:

> *'[Resident B] had her bed head at 45 degrees to prevent aspiration and choking…*
>
> *On 14 June 2017 [the Home Manager] sent a memo to all staff to instruct that Resident B be placed at a 45 degree angle at all times…'*

The panel also had sight of email correspondence dated 14 June 2017 sent by the Home Manager to staff in relation to the conversations that were had with Resident B's family, which included the following:

> *'It has been requested multiple times for Resident B to be at a 45 degree angle at all times due to comfort and digestion of food…*
>
> *I have just spent time with Resident B's family…have expressed verbal stress that [Resident B]'s lunch had been later as well, and that there have been lumps noted in the food which as addressed before, could present as a choke risk…'*

The panel noted that the email correspondence from the Home Manager sent to the staff at the Home presents Resident B as being a choking risk. The panel was satisfied that Resident B required assistance to eat safely.

The panel noted that Lucy Botting in her evidence stated: *'Resident B was prone to aspiration in accordance with her hospital admission, but she did not have a care plan in place to ensure staff fed Resident B safely/correctly and positioned her at a 45 degree angle as potentially this was a choking risk, which could have caused harm.',* as well as Lucy Botting's oral evidence, where she stated that *'Resident B was assessed as a poor swallower in hospital'*.

Taking into account all of the evidence before it, the panel was satisfied that there was a need for a care plan to be in place to ensure that staff fed Resident B safely. The panel could find no relevant care plan, and no care plan had been identified by Lucy Botting in her evidence. The panel found that Mrs Cooper failed to ensure that such a care plan was in place. The panel therefore find this charge proved.

Charge 2c(iii)

iii) A nutrition care plan and/or food intake monitoring was in place

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to carry out care planning, the reasons for which are already articulated in charge 1. The panel has also found that there is a duty to manage nutrition for all residents as articulated in its decision on charge charges 1i, 1n(iv) and 1n(v). Therefore, the panel was satisfied that Mrs Cooper had a duty to ensure that a nutrition care plan and/or food intake monitoring was in place for Resident B.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel took into account its findings in relation to 2b(vii).

The panel also took into account the following from Lucy Botting's evidence:

> *'Resident B was on a liquid diet and required assistance with all meals. She was documented as having a low appetite…*
>
> *Dr… referred Resident B to the dietician on the 12th September 2017*
>
> *On 10 October 2017 Resident B was seen by the dietician… Her current weight was noted to be 29.3kg… (morbidly underweight)… was noted to be at risk of malnutrition due to her extremely low body weight.*
>
> *The family had reported that Resident B suffered from many food intolerances and nausea and were extremely anxious about making changes to her diet…*
>
> *When Resident B was admitted to the Home she weighed 31.8kg… It was noted in the records on admissions that her MUST score was 2…'*

The panel had sight of the evidence before it that Resident B had a very low weight. This included weight charts and the MUST scoring which indicated that Resident B's food intake should be monitored. The panel noted that Resident B had been referred to the dietician and had been taking nutritional supplements. The panel had sight of Resident B's input/output charts, which show sporadic food monitoring.

The panel was satisfied that Mrs Cooper had failed to ensure that a nutrition care plan and/or food intake monitoring was in place for Resident B. The panel therefore found this charge proved.

Charge 3a)

In relation to Resident C

a) Failed to ensure that there was a monthly weight chart in their clinical records

This charge is found PROVED.

The panel has already found that there is a duty to manage nutrition for all residents, including monitoring weight as articulated in its decision on charges 1i, 1n(iv) and 1n(v). Therefore, the panel was satisfied that Mrs Cooper had a duty to ensure that that there was a monthly weight chart in Resident C's clinical records.

The panel also took into account the following from Lucy Botting's evidence:

> *'…main areas of concern with regard to Resident C*
>
> - *Weight management (to include MUST)*
>
> …
>
> *Resident C appears to have been weighed monthly from her admission. On 4 September 2016 Colleague 3 stated she weighed 59.4kg and had a MUST 1 (noted as 5ft 5).*
>
> *However, whilst there is a record of monthly MUST scores from 29 July 2016… there is no record of a monthly weight chart provided within the clinical evidence.*
>
> *These MUST scores were stable but appeared to dip in June 2017*
>
> *… staff to reweigh Resident C to check whether a loss of 12.3kg was indeed accurate… MUST scores and weight loss appear to be rectified*
>
> *A MUST risk assessment was put in place'*

The panel took into account that there are documents before it to indicate that there were MUST scores calculated, which would involve the use of Resident C's weight. There were however no correlating monthly weight charts in the records before the

panel, and Lucy Botting's report states that *'there is no record of a monthly weight chart provided within the clinical evidence'*.

Taking into account all of the evidence before it, the panel was satisfied that Mrs Cooper had failed to ensure that there was a monthly weight chart present within Resident C's clinical records. The panel therefore find this charge proved.

Charge 3b)

b) From 26 September 2017 following identification of inflammation around their catheter, failed to ensure there was a related wound management plan in place.

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to ensure that wound care planning was carried out, properly recorded and included in all residents' clinical records, the reasons for which are already articulated in charge 1.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of Resident C's Admission and Discharge Body Map dated 17 July 2017, which records inflammation around the catheter site *'red discoloured again'.*

The panel also had sight of the following from Lucy Botting's evidence:

> *'On 17 July 2017 on Resident C body map.. discolouration to sacral area… [Resident C] catheter site remained red and inflamed…*
>
> *…*
>
> *Whilst Resident C had a catheter management plan in place there was no management plan for her wound care related to this.'*

The panel was therefore satisfied that Resident C had inflammation around her catheter that required wound care.

The panel also heard oral evidence from Lucy Botting, who stated that there should have been a wound management plan put in place for Resident C.

The panel noted that it does not have before it any related wound management plan for Resident C, which is consistent with Lucy Botting's evidence that no such plan is in place. The panel therefore find this charge proved.

Charge 3c)

c) Following identification of a pressure sore on or about 5 December 2016 failed to ensure there was a wound assessment and or that a wound care plan was put in place.

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to ensure that wound care planning was carried out, properly recorded and included in all residents' clinical records, the reasons for which are already articulated in charge 1.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of the following from Lucy Botting's evidence:

> *'On 5 December 2016 a small, formed pressure sore was identified as developing on the right buttock as documented by Colleague 3. No wound assessment and no care plan were put in place. There is no further reference to this sore.'*

The panel also had sight of nursing care progress notes which are consistent with what is set out in Lucy Botting's evidence. The panel was satisfied that a pressure sore was identified in respect of Resident C on or about 5 December 2016.

The panel were provided with no evidence to suggest that a wound assessment took place or that a wound care plan was put in place for Resident C. This is supported by Lucy Botting's evidence and is consistent with the absence of documentary evidence. The panel therefore find this charge proved.

Charge 3d (in its entirety)

Following application of a dressing to a pressure sore on or about 12 March 2017, failed to ensure:

(i) It was identified whether or not this was the same pressure sore as that at 3 c) above
(ii) That there was a wound assessment and/or a wound care plan was put in place
(iii) That a body map was completed

This charge is found PROVED (in its entirety).

The panel decided to consider all of these sub-charges together as they are inextricably linked.

The panel found there was a duty for Mrs Cooper to ensure that wound care planning was carried out, properly recorded and included in all residents' clinical records, the reasons for which are already articulated in charge 1.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of the nursing care progress/evaluation notes commencing 12 March 2017, which notes *'new dressing applied right buttock'.* The notes record a pressure sore in the same place but does not identify whether this was the same pressure sore as that at charge 3(c). The panel was therefore satisfied that Resident C had a pressure sore on or around 12 March 2017.

The panel considered that there is also no other evidence in the documents before it as to whether this pressure sore is the same as that at charge 3(c) or not.

The panel also had sight of Lucy Botting's evidence in this regard:

> *'On 12 March 2017 a new dressing was applied to Resident C right buttock… it is not clear when this developed, if this continued to be the same area from December 2016, and no care plan, wound assessment or body map was completed.'*

The panel found Lucy Botting's oral evidence in this regard to be consistent and clear.

The panel noted that there is no wound assessment, wound care plan or body map in the documentary, or other evidence before it relating to a pressure sore, new or pre-existing, in Resident C's clinical notes of 12 March 2017.

The panel found this charge proved in its entirety.

Charge 3e

e) On or about 4 August 2017, following identification of a burst blister, failed to ensure that there was a wound assessment and/or a wound care plan was in place

This charge is found PROVED.

The panel had already found there was a duty for Mrs Cooper to ensure that wound care planning was carried out, properly recorded and included in all residents' clinical records, the reasons for which are already articulated in charge 1.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of Resident C's nursing care progress/evaluation notes, in particular the entry for 4 August 2017 noting *'blister that has burst'*. The panel was satisfied that Resident C had a burst blister on or about 4 August 2017.

The panel also had sight of the following from Lucy Botting's evidence:

'On 4 August 2017 a burst blister was noted to Resident C's posterior left leg… a dressing was applied. This was documented on the wound mapping chart but no care plan/ wound assessment was provided.'

The panel also heard consistent oral evidence from Lucy Botting, who stated that, in respect of wound management, there should have been a wound care plan, a body map and a wound assessment.

The panel carefully considered all of the evidence before it and was satisfied that there was no wound assessment or wound care plan in place for the burst blister identified on 4 August 2017.

Taking all of this evidence into account, the panel found this charge proved.

Charge 3f

f) On or about 7 August 2017, following identification of two skin tears, failed to ensure that there was a wound assessment and/or a wound care plan was in place

This charge is found PROVED.

The panel had already found there was a duty for Mrs Cooper to ensure that wound care planning was carried out, properly recorded and included in all residents' records, the reasons for which are already articulated in charge 1.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of Resident C's nursing care progress/evaluation notes, in particular the entry for 7 August 2017 noting *'small dressing… to top of buttocks/anal cleft x2 skin tears materialised'*. The panel was therefore satisfied that Resident C had two skin tears on or about 7 August 2017.

The panel had sight of the following from Lucy Botting's evidence:

‘On 7 August 2017 Colleague 3 documented that a small dressing was applied to the top of [Resident C] buttocks/anal cleft as she had two skin tears. No care plan/wound assessment was undertaken.’

The panel also heard consistent oral evidence from Lucy Botting, who stated that, in respect of wound management, there should have been a wound care plan, a body map and a wound assessment.

The panel carefully considered all of the evidence before it and was satisfied that there was no wound assessment or wound care plan in place for the skin tears identified on or about 7 August 2017.

Taking all of this evidence into account, the panel found this charge proved.

Charge 3g)

g) On or before 1 November 2017, failed to ensure that their room was cleaned frequently

This charge is found PROVED.

The panel decided that Mrs Cooper had a duty to ensure that all residents rooms were cleaned frequently. The panel considered Mrs Cooper’s job description for the role Home Manager, in particular:

‘Care of the Service User

- *To be responsible for the efficient running of the housekeeping and catering service in the home which will include the following:*

  …

  …

  …

  …

Ensuring that good standards of hygiene, infection control and cleanliness are maintained and exceeded.

…

Premises

- *…*
- *…*
- *To ensure that legislation and regulations concerning Environmental Health, Infection Control and Health and Safety are complied with and to advise the Board of Directors if action is required.*
- *…'*

The panel considered that Mrs Cooper's job description provides a clear duty for compliance with legislation and regulations in respect of infection control and health and safety, which would have included ensuring that all residents rooms were clean.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had sight of the Residents Personal Equipment Care Team Cleaning Schedule Commode Cleaning Record for Resident C which covers the period between 29 November 2016 and 14 April 2017. The panel heard oral evidence from Lucy Botting that these charts related to the healthcare assistants 'wiping down' as opposed to the cleaning of the room.

The panel also had sight of Lucy Botting's evidence in relation to this:

'Health care assistants were responsible for checks on Resident C room to include wheelchair cleaning, commode toilet frame cleaned and tidying wardrobes and drawers…they were also responsible for commode cleaning. Clinical records evidence this occurred between 29 November 2016 and 26 April 2017.

'It was noted by the CQC that Resident C's room was not cleaned and emitted a strong unpleasant odour. There is no evidence from the housekeeper to determine this…'

The panel took into account the following from Stephanie Patience's statement:

'… The room of one resident (Resident C) smelt very strongly…'

Whilst the panel is mindful that Stephanie Patience's statement is hearsay, this is consistent with and corroborated by the action plans exhibited and referenced by Steven Abbott in his oral evidence. The panel therefore afforded Stephanie Patience's hearsay statement appropriate weight.

The panel found that the only cleaning records referred to in relation to Resident C are the Residents Personal Equipment Care Team Cleaning Schedule Commode Cleaning Records.

The panel had no evidence before it about Resident C's room being cleaned frequently.

Taking all of this into account and considering the totality of the evidence, on the balance of probabilities, the panel found this charge proved.

Charge 4a

In relation to Resident D:

a) Failed to ensure that one or more fluid intake charts was fully completed

This charge is found PROVED.

Due to the wording of the charge being *'failed to',* the panel first considered whether Mrs Cooper had a duty to ensure that Resident D's fluid intake was being monitored.

For the reasons already articulated earlier in charge 1, the panel was of the view that the duty in this charge was directly related to the duty as a registered nurse in her role as deputy manager for systems and care planning. It also considered that the duty in this charge is also linked to Mrs Cooper's duty to ensure the weight and nutritional management of residents in the Home.

In deciding whether there was a duty for Mrs Cooper to ensure that fluid intake charts were fully completed for Resident D, the panel considered the evidence of Lucy Botting. She explained the clinical risks of inadequate hydration, including urinary tract infection, skin integrity issues and pressure area concerns and the associated need for proper records.

The panel also had sight of Mrs Cooper's job description, in particular:

'Principal Responsibilities

- *To manage the day-to-day running of the home and to act as nurse in charge whenever required to do so*
- *…*
- *To devise and implement systems for monitoring and managing the quality of the service including the auditing of all aspects of care in order to provide evidence for outcome areas of the Essential Standards of Quality and Safety*

Compliance with relevant legislation including:

- *Health and Social Care Act 2008 and subsequent amendments including Protection of Vulnerable Adults Regulations 2002'*

In light of this, the panel was satisfied that Mrs Cooper had a duty to ensure that all residents fluid intake was being monitored and recorded.

In deciding whether Mrs Cooper had failed in her duty, the panel considered Lucy Botting's evidence:

‘Attendance, intake and output charts

The fluid charts were not completely fully. There are gaps noted throughout and in some instances, it would appear that Resident D had below the reasonable level of fluid. This may be due to the fact that these charts may not have been completed correctly or because Resident D was not sufficiently hydrated. However, it is noted that she usually ate and drank well-independently.’

The panel also took into account Resident D’s fluid charts which covered the time period between 1 June 2017 to 19 October 2017. The panel found that many of the fluid charts were not filled in, with a complete absence of records between 11 July 2017 to 6 August 2017, which is a significant period of time for no fluid intake recording. The panel also noted that the total fluids written in are very low, with only a couple of hundred millilitres documented some days. The panel noted that it did not have any evidence of a review process for fluid balance charts.

The panel was therefore satisfied that one or more fluid intake charts records were not fully completed. The panel therefore found this charge proved.

Charge 4b

b) Failed to ensure one or more repositioning records were completed and/or placed with resident D’s notes on or after 3 September 2017

This charge is found PROVED.

The panel had already found there was a duty for Mrs Cooper to ensure that repositioning took place for all residents’ as required and was properly recorded and placed in residents’ clinical records as articulated in its findings in relation to charge 1a.

In reaching its decision as to whether this duty existed in respect of Resident D, the panel had sight of the following from Lucy Botting’s report:

'Whilst there is little clinical evidence provided for Resident D it is apparent that by the 3 October 2017, she had a left shoulder sore and a sore in the middle of her back. She was nursed in bed on an airflow mattress from October 2017.'

The panel also had sight of photographs of Resident D's skin included within the evidence before it, which showed fragile, vulnerable and damaged areas.

The panel noted the following from Resident D's clinical notes dated 3 October 2017, reinforcing the need for repositioning records:

'Resident D is now being nursed in bed with bed rails and bumpers due to a deterioration in her condition'

A further entry dated 3 August 2017 stated:

'Pressure areas all intact, no wounds at present although Resident D is prone to skin tears due to her fragile skin'

Taking all of this evidence into account, the panel was satisfied that Resident D was clearly identified as being at significant risk of pressure damage, and repositioning was an essential component of their care.

In deciding whether Mrs Cooper had failed in her duty, the panel had sight of the following from Lucy Botting's report:

'repositioning records are also missing from 3 September 2017'.

The panel undertook its own review of the documentation before it and was unable to locate any repositioning records for the relevant period.

The panel found that Mrs Cooper had failed in her duty to ensure that one or more repositioning records were completed and/or placed with Resident D's notes on or after 3 September 2017. The panel therefore finds this charge proved.

Charge 4c(i)

c) On or before 1 November 2017, failed to ensure that:

i) A pressure area care plan was in place

This charge is found PROVED.
The panel had already found there was a duty for Mrs Cooper to ensure that residents underwent assessment of their care needs and had care plans in place, the reasons for which are already articulated in charge 1.

In reaching its decision as to whether Resident D required a pressure area care plan, the panel had sight of photographs of Resident D's skin included within the NMC bundle, which showed fragile, vulnerable and damaged areas.

The panel also had sight of Resident D's clinical notes, which indicated that Resident D was at a very high risk of pressure ulcer development from August 2017 through October 2017. It also had sight of Resident D's Waterlow Score Chart, which showed consistently high Waterlow scores.

The panel was therefore satisfied that on or before 1 November 2017, Resident D required a pressure area care plan.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel took into account the following from Lucy Botting's report:

> *'Whilst these specific pressure points were identified, no pressure area preventative care plans and no wound assessments were put in place'*

The panel accepted Lucy Botting's evidence within her report, that she was unable to locate any pressure area care plan within the records, and no such plan was produced in evidence before the panel.

In light of all the evidence before it, the panel was satisfied that Mrs Cooper failed to ensure that a pressure area care plan was in place for Resident D on or before 1 November 2017. The panel therefore finds this charge proved.

Charge 4c(ii)

ii) A wound care plan was in place for one or more wounds on Resident D's arms

This charge is found PROVED.

The panel had already found that there was a duty for Mrs Cooper to ensure that wound care planning was carried out, properly recorded and included in the clinical records of all residents who had wounds, the reasons for which are already articulated in charge 1.

In reaching its decision as to whether Resident D required a wound care plan, the panel had sight of photographs of Resident D's arm wounds, which showed wounds present on the left upper arm, left lower arm and also other areas.

The panel also had sight of Resident D's skin tear documentation dated 7 July 2017, which confirmed a site of wound at the *'[left] wrist near back of hand'.*

The panel also had before it Resident D's body maps covering the time period between July 2017 to October 2017, which showed wounds to their arms.

The panel was therefore satisfied that Resident D required a wound care plan on or before 1 November 2017.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel considered that it had evidence before it of some wound care plans for wounds on

Resident D's arms. However, not all wounds had a care plan. The panel noted the absence of wound care plans for a left wrist skin tear on 17 July 2017, and the forearm wound dated 3 July 2017.

The panel was satisfied that Mrs Cooper failed to ensure that wound care plans were in place for one or more wounds on Resident D's arms on or before 1 November 2017. The panel therefore finds this charge proved.

Charge 5a

In relation to Resident E, on or before 1 November 2017, failed to ensure that

a) A care plan for a pressure sore was in place

This charge is found PROVED.

The panel had already found that there was a duty for Mrs Cooper to ensure that wound care planning was carried out, properly recorded and included in the clinical records of all residents who had wounds, the reasons for which are already articulated in charge 1. The panel was satisfied that the terms 'pressure ulcer' and 'pressure sore' are used interchangeably in the evidence before it and are synonymous terms.

In considering whether Resident E required a pressure sore care plan, the panel considered the evidence of Lucy Botting:

> *'Resident E… we were advised during the October 2017 inspection that they had a sacral pressure ulcer. We noted that the body map records indicated the sore had been there since 13 September 2017…'*

The panel had sight of Resident E's clinical nursing notes dated 6 September 2017 which referenced a referral to the Tissue Viability Nurse, and a body map record dated 1 October 2017 which showed the presence of pressure ulcers. The panel was satisfied that Resident E required a pressure sore care plan on or before 1 November 2017.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel took into account the CQC email to the CCG dated 1 November 2017 which set out the following in relation to Resident E:

'… No care planning in place. Pressure ulcer to sacrum at present...'

The panel accepted Lucy Botting's evidence that no pressure sore care plan could be located for Resident E during the relevant period. There is also no such plan in the evidence before the panel.

Taking all of this evidence into account, the panel was satisfied that on or before 1 November 2017, Mrs Cooper had failed to ensure that a pressure sore care plan was in place. The panel therefore find this charge proved.

Charge 5b

b) Measures to prevent further skin breakdown were in place

This charge is found PROVED.

The panel had already found that Mrs Cooper had a duty to ensure that measures to prevent further skin breakdown were in place, the reasons for which are already articulated in its findings in relation to charge 1. In reaching its decision, the panel also took into account its findings as set out in charge 5a.

The panel took into account the Waterlow Score Chart dated 7 September 2017 and 7 October 2017, the body map dated 1 October 2017 and Resident E's Nursing Care Progress/Evaluation clinical note indicating the need for tissue viability input. The panel was therefore satisfied that Resident E was at a high risk of pressure area damage and required further measures to be in place to prevent further skin breakdown.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel considered all of the evidence and could not identify any preventative measures that were in place during this period.

The panel was therefore satisfied, on the balance of probabilities, that Mrs Cooper had failed to ensure that appropriate measures to prevent further skin breakdown were in place for Resident E on or before 1 November 2017. The panel therefore finds this charge proved.

Charge 6a

In relation to Resident F

a) On one or more occasions failed to ensure it was clear whether Resident F had insufficient hydration or intake was not recorded

This charge is found PROVED.

In reaching its decision, the panel took into account its previous findings in relation to charge 4a, that Mrs Cooper had a duty to ensure that all residents' fluid intake and hydration were appropriately monitored and recorded. The panel also took into account that this duty extended to ensuring that documentation was clear in demonstrating that residents had received sufficient hydration. The panel was satisfied that this duty extended to Resident F.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel considered Lucy Botting's evidence:

> *'On 24 March 2016 there was a meeting between social services and the family…There were noted issues around food and fluid intake…*
>
> *…*

On 24 June 2016 the Home spoke with Dr… re Resident F fluid intake. It was noted that she had vigilant charts and that fluid was to be offered

On 10 November 2016 Resident F had offensive urine. Fluids were encouraged

…

There are two main areas of potential concern with regard to Resident F

- *Fluid Management*
- *…*

…

Resident F fluid charts were recorded daily by carers and were totalled to estimate intake over a 24-hour period. However, it is still clear that she did not drink sufficiently well and these fluid intake charts did not take into account her Fresubin drinks, complan shakes or any liquid intake from her meals (for instance soup or porridge). Therefore, whilst some of the total intakes are low, it is unclear whether this is recorded correctly and carers forgot to complete these charts or indeed Resident F has insufficient hydration.' [sic]

The panel had sight of Resident F's daily fluid charts covering the time period from 25 October 2017 to 30 October 2017. It noted that the entries were sporadic and incomplete, with some recorded daily totals of fluid intake as low as 400ml.

In addition to this, the panel also had before it Attendance, Input and Output Charts for Resident F covering 2016 and 2017, which were unclear. These charts included entries stating, *'drink available'* or *'beaker of tea left'*, without indicating whether any fluid had actually been consumed by Resident F.

The panel also took into account Elena Marin's evidence which includes an account of her encouraging Resident F to eat and drink. She reported that food and drink were

often left in front of Resident F with no staff encouragement or supervision. The panel considered that this would have been necessary in order to encourage adequate intake for Resident F.

The panel was satisfied that Mrs Cooper had failed to ensure it was clear whether Resident F had insufficient hydration or if the intake was not recorded. The panel therefore found this charge proved.

Charge 6b)

b) Having been requested to provide a pressure mat, failed to ensure that a pressure mat was provided and/or that a pressure area care plan was in place

This charge is found PROVED (in respect of the second limb relating to a pressure area care plan).

The panel had already found there was a duty for Mrs Cooper to ensure that residents underwent assessment of their care needs and had care plans in place, the reasons for which are already articulated in charges 1 and 4c(i).

When considering whether there was a duty for Mrs Cooper to provide a pressure mat when requested, the panel have been unable to identify evidence that any such request was made. The panel was therefore satisfied that a duty to provide a pressure mat did not arise.

The panel then went on to consider the second limb of the charge, namely that a pressure area care plan was in place.

In considering whether Resident F required a pressure area care plan, the panel considered Resident F's Waterlow Scores from December 2015 to September 2016, which showed them to be in the 'at risk to very high risk' range for pressure damage. This is corroborated by Lucy Botting's evidence:

'Resident F was at risk of pressure ulcer development (waterlow 17) when she was admitted to Lound Hall. This increased to very high risk (score 20 and above) after the 31 May 2016 and remained such until 2017. However, there is no pressure area care plan...'

The panel was therefore satisfied that Resident F required a pressure area care plan to be in place.

In considering whether Mrs Cooper failed in her duty, the panel carefully considered all of the evidence and noted that it could not identify any evidence of a pressure area care plan being in place. The panel therefore finds this charge proved in respect of the second limb only.

Charge 6c

c) Failed to ensure assistance was given for Resident F to feed

This charge is found PROVED

The panel found there was a duty for Mrs Cooper to carry out care planning, the reasons for which are already articulated in charge 1. The panel has also found that there was a duty to manage nutrition for all residents as articulated in its decision on charges 1i, 1n(iv) and 1n(v). The panel was therefore satisfied that Mrs Cooper had a duty to ensure that staff assisted all residents who required support when eating.

In considering whether Resident F required support when eating, the panel had sight of a letter which related to Resident F's referral to the dietician dated 4 August 2016 for advice on her poor oral intake and weight loss:

'Her current weight is 40.9kg…(severely underweight) She has lost -9kg since her admission in December 2015… She is at high risk of malnutrition due to her low body weight and significant weight loss.

Her oral intake is small and her intake can be variable. She requires a lot of encouragement and prompting, especially with drinks…'

The panel also took into account the following from Lucy Botting's evidence in respect of Resident F being reviewed by the dietician:

*'**Dietary intake**.*

…It also came to light from her family members that she often bought food and didn't eat this and had been anorexic in the past…The care home put in place a Nutrition and Hydration Care Plan…It was documented that she could forget to eat and drink and needed prompting.. Her oral intake was noted to be very small and she needed a lot of encouragement…

On 4 September 2017 Resident F was visited by the dietician… It was noted that Resident F appetite remained poor. She often refused food…'

The panel also took into account Elena Marin's evidence which includes an account of her encouraging Resident F to eat and drink. She reported that food and drink were often left in front of Resident F with no staff encouragement or supervision.

The panel was therefore satisfied that Resident F required assistance when eating.

In considering whether Mrs Cooper failed in her duty, the panel noted that there was no evidence that any such assistance was provided to Resident F when eating. The panel therefore find this charge proved.

Charge 6d(i)

d) On or before 1 November 2017, failed to ensure that:

i) Staff had checked Resident F's sacrum for a pressure sore since 20 September 2017

This charge is found PROVED.

The panel had already found that there was a duty for Mrs Cooper to ensure that pressure sore care planning was carried out, properly recorded and included in the clinical records of all residents who were at risk of pressure sores, the reasons for which are already articulated in its findings in relation to charges 1, 2b(vii), 3(c) and 5a.

In reaching its decision as to whether Mrs Cooper had a duty in respect of Resident F, the panel took into account Resident F's waterlow score, which showed very high-risk scores between 28 February 2017 and 19 September 2017. The panel was therefore satisfied that Resident F was at high risk of pressure sores and that Mrs Cooper should have ensured that staff had checked Resident F's sacrum.

In reaching this decision as to whether Mrs Cooper had failed in her duty, the panel noted Lucy Botting's evidence:

> *'**Lack of documentation in relation to Pressure Area Care***
>
> *Resident F was a t risk of pressure ulcer development (waterlow 17) when she was admitted to the Home. This increased to very high risk (score 20 and above) after the 31 May 2016 and remained such until 2017. However, there is no pressure area care plan and it is unclear the type of mattress type that Resident F had on her bed (at one stage this is referenced as a foam mattress then air flow mattress but dates are unclear) and how the staff were mitigating actions of pressure ulcer development.'*

The panel noted the body map check for Resident F recorded that their sacrum was checked on 19 July, 19 August and 20 September 2017. The last recording refers to discolouration of the sacrum. No further checks of Resident F's sacrum are recorded.

The panel could not find any reference in the documentation before it that Resident F's sacrum had been checked for a pressure sore since 20 September 2017. The panel finds this charge proved on the balance of probabilities.

Charge 6d(ii)

ii) Measures to prevent further skin breakdown were in place

This charge is found PROVED.

The panel had already found that there was a duty for Mrs Cooper to ensure that measures to prevent further skin breakdown were carried out, properly recorded and included in resident's clinical records, the reasons for which are already articulated in its findings in relation to charges 1 and 5b. The panel took the view that on a fair reading, 6d(i) and 6d(ii) are closely related and treated the latter as deriving from the former.

The panel therefore took into account its findings in relation to charge 6d(i), namely staff had not checked Resident F's sacrum for a pressure sore since 20 September 2017. In light of this, the panel was satisfied that Mrs Cooper failed to ensure that measures to prevent further skin breakdown were in place on or before 1 November 2017. The panel therefore found this charge proved.

Charge 6d(iii)

iii) A fall care plan was in place

This charge is found NOT PROVED.

The panel had already found there was a duty for Mrs Cooper to ensure that care planning took place, properly recorded and included in all residents' clinical records, the reasons for which are already articulated in its findings in relation to charge 1. Therefore, the panel is satisfied that a falls care plan should be in place for any resident at risk of falls.

In reaching its decision about whether Resident F was at risk of falls, the panel had sight of a summary included in Lucy Botting's report as to falls management in respect

of Resident F who was *'at very high risk of falls'* and the consequent need for a care plan. The panel also had sight of the chronology for Resident F's clinical reports included in Lucy Botting's report. The panel was satisfied that a falls care plan was required for Resident F.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel found from the evidence before it that there was a moving and handling plan to prevent and respond to Resident F's risk of falls dated 9 April 2017, which is also mentioned in Lucy Botting's evidence. It noted from Lucy Botting's evidence that whilst the moving and handling care plan was not explicitly described as a falls care plan, in substance it contained all the necessary elements of a falls care plan. In this regard, the panel took account of the following extract from Lucy Botting's report:

> *'…on each occasion she fell Resident F had a completed accident from and the family were informed…the Home had put in place all reasonable mitigations/management for her falls, noting there can never be a zero tolerance on falls. The only next steps would have been for the CHC/social care to fund a 1:1 placement to further mitigate falls. This would not have been the responsibility of the Home to put this in place…'*

In addition, the panel also heard oral evidence from Lucy Botting which supported the above.

Taking all of this evidence into account, the panel was satisfied that a falls care plan for Resident F was in substance within the moving and handling plan. The panel therefore found this charge not proved.

Charge 8a

In relation to Resident I:

a) Failed to ensure that they had adequate fluid intake and/or that fluid intake was recorded correctly

This charge is found PROVED.

The panel had found that there was a duty for Mrs Cooper to ensure both adequate fluid intake occurred and that the fluid intake was recorded correctly for all residents for the reasons already articulated in charges 4a and 6a.

In deciding whether this duty applied to Resident I, the panel noted the following from Lucy Botting's evidence:

> *'Resident I … had recurrent urinary tract infections and was noted to be sleepy with low blood pressure.*
>
> *…following a blood test in 2017…identified she had dehydration…'*

The panel also had sight of an undated letter addressed to Resident I's GP received from Norfolk and Suffolk Trust, which details that they *'have a long-standing condition which affects your kidneys'.*

The letter also refers to Resident I's dehydration indicated by blood test results. It is further stated that as a result of her dehydration, Resident I could be experiencing muscle spasms or cramps which could also account for her unsettled nights. The panel also noted that because *'Resident I is already dehydrated staff will need to really encourage fluids due to the risks of urination changes and increased risks of UTIs'.* The panel was therefore satisfied that Mrs Cooper had a duty to ensure Resident I had adequate fluid intake and/or that it was recorded correctly.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel took into account Resident I's Nursing Care Progress/Evaluation notes, with an entry dated 1 July 2017 *'to push fluids'*. The panel also had before it Resident I's fluid charts covering the dates between 22 February 2017 to 31 October 2017, and Resident I's care plan for fluid intake dated 30 November 2012.

The panel found that the records before it showed low volumes of fluid consumption recorded indicating an inadequate fluid intake. The panel also found that there was a wide disparity of volumes of fluid recorded, for example, one day showing a total of 280ml and the next day showing 1300mls. Another daily fluid chart dated 31 October 2017 showed a target of 1200mls and a documented total of 850mls with no explanation for why Resident F had an inadequate intake of fluid.

The panel noted that some of the records showed gaps and that fluid intake had not been recorded accurately, with one record for example stating, *'tea left to drink'*, which does not constitute correct recording of fluid intake.

Taking into account all of the evidence before it, the panel found this charge proved.

Charge 8b

b) Failed to ensure that a care plan for urinary tract infections was in place

This charge is found PROVED.

The panel had found there was a duty for Mrs Cooper to ensure that care planning took place, was properly recorded and included in all residents' clinical records, the reasons for which are already articulated in its findings in relation to charge 1. Therefore, the panel is satisfied that a care plan for urinary tract infections should be in place for any resident suffering from or at risk of urinary tract infections.

In considering whether Resident I required such a care plan, the panel noted the evidence that Resident I had recurrent urinary tract infections.

Lucy Botting gave evidence that '*Resident I was noted to have … recurrent urinary tract infections...'.*

The panel also took into account the following from Lucy Botting's evidence which included a chronology in relation to Resident I:

'On 25 May 2012 she was seen by Dr.. for weight loss and a UTI…

…

On 24 June 2015 Resident I was commenced on amoxicillin for a urinary tract infection…

…

On 28 August 2015 she was seen by Dr… a urine sample was requested…

…

A urine sample was collected on the 26 May 2016 as documented by Colleague 2

On the 26 May 2016 Dr… stated the urine sample was positive. Antibiotics were prescribed…

On 9 January 2017 Resident I was seen by Dr…He requested a further urinalysis…

On 3 August 2017 Resident I was seen by Dr…A urine sample was also requested…

On 16 August 2017 Resident I was agitated in the afternoon…documented that urine should be checked for infection…

On 25 August 2017 her urine result was positive. A prescription of antibiotics was provided for a urinary tract infection…

…

On 7 September 2017 Resident I was seen by Dr… A urine sample requested '

The panel was therefore satisfied that Resident I required a care plan for urinary tract infections.

The panel considered all of the evidence before it and was unable to identify any care plans for urinary tract infection for Resident I. The panel therefore found this charge proved.

Charge 10a

10 In relation to Resident K:

a) Failed to ensure that one or more wounds was described in a wound assessment chart, and/or body mapped and/or photographed

This charge is found PROVED.

The panel found there was a duty for Mrs Cooper to ensure that care planning was undertaken, a key aspect of which is completion of wound assessment charts, body maps and photographs. These must be properly recorded and included in the clinical records of all residents with wounds, the reasons for which are already articulated in the panel's findings in relation to charge 1.

In deciding whether Resident K had a wound, the panel took into account the following from Lucy Botting's report which included a chronology in relation to Resident K, extracts of which include:

'On 26th December 2015 a cut to Resident K left knee was noted. The nurse was said to be informed by care staff…

…

On 29th January 2016 Resident K had a cut to his left leg. A dressing was put in place by …

…

On 9th March 2016 Resident K was found to be scratching his leg which was bleeding. A new dressing was applied… There was still not wound assessment in place.

…

On 5th May 2016 he had scratched his left leg and this appeared to be bleeding. A dressing was applied by Colleague 4.

…

On 1st August 2016 Resident K had an unwitnessed fall at 17:00. He had a head injury on the right side of face and right eye. He was seen by the paramedics and Colleague 2 and his wounds cleaned, steristrip applied and he was left on scene – within the home…

…

On 11th August 2016 Resident K was bleeding from his right elbow. This was redressed…

…

On 1st July 2017 Resident K's skin appeared sore around his shoulders as documented by Colleague 2. A small dressing was applied.'

The panel also had sight of Resident K's accident forms covering April 2017, August 2017, September 2017 and October 2017, some of which do document that there were wounds/lacerations and injuries from falls.

The panel had sight of a falls diary for Resident K dated 9 November 2017, where there is a mention of a small laceration on the right knee, with a small dressing applied and vital signs were checked.

The panel was therefore satisfied that Resident K had one or more wounds which Mrs Cooper had a duty to ensure were described in a wound assessment chart, and/or body mapped and/or photographed.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel noted the following from Lucy Botting's evidence in relation to Resident K:

> *'Wound management*
>
> *Due to Resident K scratching his skin (psoriatic) and due to his multiple falls, he would often require dressing to his skin. Whilst documented within the daily clinical notes, these wounds were not described on a wound assessment chart, body mapped or photographed.*
>
> *Body maps were undertaken on his admission but no body map was then undertaken until 20 July 2017 when it was identified that he had a scratch to his left leg and on 12 September 2017 (due to his fall) a bruise to his shoulder blades, bruises to his right flank and a graze to his left arm and further on the 26 September 2017 bruises to both knees, right hip and left rib cage.'*

The panel had sight of Resident K's nursing care progress evaluation notes for January 2016 and September 2017, as well as a body map dated 21 December 2015. The panel took into account that along with the existence of a body map,

there should also have been corresponding photographs and an assessment as stated by Lucy Botting in her evidence.

The panel carefully considered the evidence and noted that Resident K had a number of wounds, as described above, for which there were no wound assessment chart, and/or body maps and/or photographs.

The panel therefore find this charge proved.

Charge 10b

10 In relation to Resident K:

b) In early 2017, following weight loss of approximately 10kg since admission, failed to ensure that referral to a dietician was made

This charge is found PROVED.

The panel has already found that Mrs Cooper had a duty in respect of weight management for all residents as articulated in its decisions on charges 1c, 1e, 1g, 1k and 1l.

In reaching its decision as to whether Resident K had experienced a weight loss of approximately 10kg since admission, the panel had sight of the following from Lucy Botting's evidence:

> *'On admission Resident K weighed 78.1kg. During his admitted stay he dropped to 64.4kg in July 2017. Whilst it is noted that he enjoyed his food, it was also documented from his admission notes and within his nutrition plan that he needed encouragement due to his dementia. Food charts indicate that he was eating on a daily basis, but this was not sufficient to maintain his weight. A dietetic referral should have been considered in*

early 2017 when he had lost 10kg. This appears not to have been considered.

<u>Weight charts</u>

Jan 2016 weight 78.1kg – recorded by Colleague 3
Feb 2016 weight 76.2kg – recorded by Colleague 3
March 2016 weight 76.7kg – recorded by Colleague 3
April 2016 weight 73.5kg – recorded by Colleague 3
May 2016 weight 73kg – recorded by Colleague 3
June 2016 weight 71.7kg – recorded by Colleague 3
July 2016 weight 72.8kg – recorded by Colleague 3
Sept 2016 weight 72kg – recorded by Colleague 3
Oct 2016 weight 67.5kg - recorded by Colleague 3
Dec 2016 weight 68.9kg – recorded by …
Jan 2017 weight 68.9kg – recorded by Colleague 3
Feb 2017 weight 68.2kg - recorded by Colleague 3
March 2017 weight 69.9kg - recorded by Colleague 3
April 2017 weight 68.2kg - recorded by Colleague 3
May 2017 weight 68kg – recorded by Colleague 3
June 2017 weight 69kg BM1 23 - recorded by Colleague 3
July 2017 weight 64.4kg BMI 21. MUST 1 lost weight 5-10% of body weight. +- recorded by …
August 2017 weight 68.1kg – recorded by …
September 2017 weight 64.2kg BMI 21. MUST 1. – Recorded by …'

The panel also had sight of the corresponding weight charts for Resident K which cover January 2016 to July 2017 and notes a weight of 78.1kg by January 2016, which dropped to 68kg by January 2017, which accords with the date set out in this charge.

The panel was therefore satisfied that Resident K had a weight loss of approximately 10kg from admission to early 2017.

The panel carefully considered all of the evidence and could not find any evidence that a referral to the dietician was made. The panel therefore find this charge proved.

Charge 11

11 In relation to Resident M, failed to ensure that their person-centred care plan:

a) Included food preferences

c) Recorded preferences for washing, dressing, and personal care

This charge is found NOT PROVED.

The panel considered both of these sub-charges together as they are inextricably linked.

The panel first considered that no date range has been provided within the wording of this charge.

The panel has already found that Mrs Cooper had a duty for care planning for all residents as articulated in its decision at charge 1.

The panel also considered that there is no care plan before it. It had sight of a pre-admissions sheet which indicates that Resident M has dietary needs, that her appetite is variable, needs a pureed diet, supplement drinks twice a day and full support when eating.

The panel also had sight of Stephanie Patience's witness statement, which states the following in relation to Resident M:

‘Resident M

We observed that the ‘person centred care summary’ for Resident M did not state their food preferences and did not specify what foods increased their bowel movement frequency. No preferences as to washing, dressing and personal care were completed for Resident M.’

However the panel considered that whilst Stephanie Patience had observed the above in relation to Resident M as part of the CQC inspection, it is not clear to the panel whether a ‘person centred care summary’ is the same as a ‘person centred care plan’. In any event, Resident M’s food preferences and recorded preferences for washing, dressing and personal care are not included in the person-centred care summary.

The panel also took into account that there is no mention of Resident M’s person-centred care plan within Lucy Botting’s report.

Given that there was no person-centred care plan in evidence before the panel, the panel could not find this charge proved.

Charge 12

12 In relation to Resident N, on or before 1 November 2017, failed to ensure that their care plan identified any need for support or equipment to eat, and/or that their eating preferences were being observed

This charge is found NOT PROVED.

The panel had already found that Mrs Cooper had a duty to all residents in respect of care planning as already articulated in its findings at charge 1. The panel has also found that Mrs Cooper had a duty in respect of identifying needs for support or equipment to eat, and/or that their eating preferences were being observed as already articulated in its findings at charges 2(c)(ii) and 6(c).

In reaching its decision as to whether Resident N required support or equipment to eat, the panel took into account the evidence of Stephanie Patience. It also took into account Resident N's care plans dated 19 April 2016 and 16 June 2017, as well as the nursing care progress evaluation which covered the time period between 1- 12 January 2016.

The panel also had sight of the following from Stephanie Patience's witness statement:

> *'We also noted that Resident N struggled to eat their food on 31 October 2017, but their care plan did not identify the need for any support or equipment when eating. Their 'person centred care summary' stated that Resident N did not like pasta, but this was what we observed them to be eating during our inspection, suggesting that residents' preferences were not being observed.'*

While this evidence is noted, this conflicts with the evidence from the care plan as noted below and the panel is mindful that Stephanie Patience's statement relates to her observations on 31 October 2017 only. Stephanie Patience noted that Resident N struggled to eat on that date, but in the absence of further detail, the panel cannot be satisfied that Resident N needed any support or equipment when eating. The panel were unable to question Stephanie Patience on this point due to her unavailability at the hearing.

The panel had sight of the following extract from Resident N's care plan dated 16 June 2017 in relation to the actions and support to be provided:

> *'Resident N eats a diet low in fat, high in protein and antioxidants and normal portion size*
>
> *Resident N is independently able to feed himself and can independently choose his own meal options daily*

Resident N likes to drink tea with a small amount of sugar in a cup and cols drinks from a glass

Resident N dislikes pasta, red cabbage, rice and salad

Kitchen staff are aware of Resident N nutritional requirements and accommodate this accordingly

Resident N had a MUST score of 0 that is evaluated monthly

All dietary intake is recorded by care staff for monitoring purposes' [sic]

The panel noted based on this care plan that Resident N is independently able to feed himself, and there is no evidence before it within the nursing notes that Resident N needed assistance in the form of support or equipment. The panel therefore found that Mrs Cooper's duties to ensure that Resident M had support or equipment to eat were not engaged.

The panel noted that Resident N's eating preferences were documented in their care plan and indicated that Resident N did not like pasta. Whilst Stephanie Patience observed Resident N eating pasta on 31 October 2017, the panel noted that her evidence is hearsay. The panel also took into account that there is nothing to corroborate Stephanie Patience's evidence on this point and given that her evidence is sole and decisive in relation to this element of the charge, the panel were not satisfied that this element of the charge had been proved on the balance of probabilities.

Charge 13a

13 In relation to Resident O:

a) Failed to ensure that they were weighed or weights were recorded on admission and/or prior to December 2015

This charge is found PROVED.

The panel has already determined that Mrs Cooper had a duty in relation to the weight management of all residents, which included a duty to weigh and clearly record the assessment of residents weight, the reasons for which are already articulated in charge 1.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel had regard to the evidence of Lucy Botting. The panel also had regard to the clinical records of Resident O, including the pre-admission assessment documentation dated July 2015, the Kardex audit dated March 2017 and the weight chart covering the period 18 July 2015 until September 2017.

The panel noted that on Resident O's admission documentation, the box for weight was not completed and contained the comment *'Weight: ??'*. The panel further noted Lucy Botting's evidence that Resident O was admitted on 7 July 2015, but that no weight was recorded on admission and that the next recorded weight was not until 5 December 2015:

> *'On 5th December 2015 Resident O weight is recorded as 58.7kg…'*

The panel was therefore satisfied that Mrs Cooper had failed to ensure that Resident O was weighed, or that her weight was recorded, on admission and/or prior to December 2015. Therefore, the panel was satisfied that this charge is proved.

Charge 13b

b) Following a pressure mattress being put in place on or around 27 October 2015, failed to ensure that it was checked regularly to ensure it was working and at the correct setting, or that there were any or adequate records of such checks

This charge is found PROVED.

The panel has already determined that Mrs Cooper had a duty to ensure that any pressure mattress that was put in place was working and at the correct setting, and that there were adequate records of such checks as articulated at its findings at charge 1(n)(i).

In reaching its decision as to whether Resident O had a pressure mattress in place, the panel had regard to Lucy Botting's evidence:

> *'On 27th October 2015, it was documented by staff Nurse … that a new air flow mattress was put on the bed…'*

The panel further had regard to the evidence of Jayne Jode:

> *'… a high pressure relieving mattress was in situ…'*

The panel was therefore satisfied that Resident O had a pressure mattress in situ and that Mrs Cooper's duty to ensure that it was checked regularly was engaged.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel considered Lucy Botting's evidence

> *'A review of the alternating mattress indicated this was on a low pressure not a normal pressure, which the TVN stated could be a fault.'*

The panel carefully considered all the evidence before it and was satisfied that there was no evidence of Resident O's pressure mattress being checked regularly to ensure that it was working and at the correct setting, or that there were any or adequate records of such checks. The panel therefore finds Charge 13(b) proved.

Charge 13c

c) Failed to ensure that a Resuscitation care plan dated 18 July 2015 was completed, and/or personalised, and/or signed by Resident O

This charge is found NOT PROVED.

The panel had already found that Mrs Cooper had a duty in relation to care planning as articulated in its previous findings at charge 1.

The panel then went on to consider whether this duty extended to the provision of a resuscitation care plan for Resident O. The panel noted that there was a resuscitation care plan dated 18 July 2015, which was not completed and/or personalised and/or signed by Resident O.

However, the panel noted that Resident O had a DNACPR form in place which was initially completed and dated 21 December 2011 and updated on 18 July 2017. The DNACPR form was completed by the GP who was the senior responsible clinician. The panel found that this document contained all the necessary elements of a resuscitation plan and therefore was not satisfied that Mrs Cooper had a duty to provide a separate care plan. The panel found this charge not proved.

Charge 13d

d) Failed to ensure that a Socialisation care plan updated on 16 January 2016 was personalised and/or signed by resident O and/or corresponded to activity charts

This charge is found PROVED.

The panel was already satisfied that Mrs Cooper had a duty in relation to care planning for all residents, the reasons for which are already articulated in its findings at charge 1.

In reaching its decision as to whether Resident O required a socialisation care plan, the panel had regard to Lucy Botting’s evidence:

‘She was a frail lady and was unable to mobilise and was confined to her bed…

…

Her clinical notes identify that she was depressed and of low mood’

The panel noted that Mrs Cooper’s job description required her to *‘ensure that the emotional, spiritual, physical, mental and material needs of the service users are recognised, assessed and met’.*

The panel was therefore satisfied, given Resident O’s immobility and low mood, there was a duty to ensure that a socialisation care plan was in place.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel noted that Resident O did have a socialisation care plan which was updated on 16 January 2016.

The panel had regard to the socialisation care plan updated on 16 January 2016, together with the activity records for week commencing 21 February 2016. The panel also had regard to the socialisation care plan which recorded: *‘Resident O enjoys staying in bed and watching television, old style films and sports.*’

The panel noted Lucy Botting’s evidence that Resident O had been very active in her earlier life and found that this care plan contained limited personalised options for Resident O. The panel noted that the care plan was not signed by Resident O. The panel was therefore satisfied that the socialisation care plan updated on 16 January 2016 was not personalised and/or signed by Resident O.

The panel noted the existence of activity charts commencing 21 February 2016 for Resident O. The panel considered that the only activity documented in Resident O’s activity charts is watching television. The panel noted Lucy Botting’s evidence that, for someone who had been active earlier in life, the records showed very little meaningful

stimulation for Resident O. However, the panel did find that this corresponded with Resident O's socialisation care plan which stated that Resident O liked to stay in bed watching television. The panel therefore found this element of the charge not proved.

The panel was nevertheless satisfied on the balance of probabilities that the charge is proved because the care plan was not personalised and/or signed.

Charge 13e

e) Failed to ensure that any or adequate activity stimulation was provided and/or recorded for Resident O

This charge is found PROVED.

The panel had already decided that Mrs Cooper had a duty to provide adequate activity stimulation and/or record that stimulation for Resident O for the reasons already articulated in charge 13(d).

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel had regard to the documentary evidence relating to Resident O's care, including Resident O's activity charts and the evidence of Lucy Botting.

The panel noted that the activity charts of Resident O were only partially completed with periods of time when there were no records of the activity stimulation provided.

The panel therefore find this charge proved.

Charge 13f

f) Failed to ensure that one or more risk assessments carried out on or about 10 April 2017 was updated regularly

This charge is found NOT PROVED.

The panel was satisfied that Mrs Cooper had a duty to carry out and regularly update risk assessments for all residents at the Home in accordance with the requirements of nursing standards as set out in Mrs Cooper's job description:

> *'Purpose of position*
>
> *…*
>
> *To promote and ensure a safe and caring environment for residents through high standards of professional practice, which are conducive to the physical, emotional, social, intellectual and spiritual needs of the service users.*
>
> *…*
>
> *To implement the legal requirements pertinent to Care Homes providing Nursing Care including the Essential Standards of Quality and Safety as well as older legislation such as the National Minimum Standards for Care Homes for Older People in accordance with the Health and Social Care Act 2008, including any subsequent changes in legislation and current clinical best practices.'*

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel considered all of the documentary evidence before it relating to risk assessments. This included, but is not limited to, the bed rails risk assessment, dysphagia risk assessment and controlled medication risk assessment. It also considered the evidence of Lucy Botting.

The panel identified from the evidence before it that the only risk assessment for Resident O carried out on or about 10 April 2017 was the dysphagia risk assessment.

The panel noted that this dysphagia risk assessment was subsequently updated on multiple occasions, including entries dated 31 May 2017, July 2017, August 2017 and September 2017.

Taking into account all of the evidence before it, the panel was satisfied that the dysphagia risk assessment was updated regularly. The panel therefore find this charge not proved.

Charge 13g

g) Failed adequately or at all to ensure that Abbey Pain Scale documentation for Resident O was completed daily

This charge is found NOT PROVED.

On review of Mrs Cooper's job description, Ms Botting's evidence regarding the NMC standards of proficiency for nurses and the NMC Code, the panel found that there was a duty for Mrs Cooper as a registered nurse in her role as deputy manager to ensure that Resident O's pain was assessed and managed. However, the panel did not have any evidence that this specifically needed to be done by completing the Abbey Pain Scale. There were no policies or procedures in evidence before the panel which specifically set out which documentation should be used when assessing and managing pain. The panel noted that there were a variety of different documents in use at the Home for recording pain.

Accordingly, the panel cannot be satisfied that a duty existed to complete the Abbey Pain Scale daily or at all as alleged.

The panel therefore find this charge not proved.

Charge 13h

h) Failed to ensure that Resident O was weighed and/or weights were recorded between November 2016 and June 2017

This charge is found PROVED.

The panel was satisfied that Mrs Cooper had a duty to ensure that Resident O was weighed and/or weights were recorded for the reasons already articulated at charges 1(c), 1(e), 1(g), 1(k) and 1(l).

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel had regard to the documentary evidence relating to Resident O's weight monitoring, which included the chronology set out by Lucy Botting in her report and the contemporaneous weight chart dated 18 July 2015 spanning the period between July 2015 to September 2017.

The panel had sight of the chronology set out in Lucy Botting's report, which includes two entries in relation to Resident O's weight between November 2016 and June 2017:

'On 30th November 2016 Resident O's weight was recorded as 55.7kg…

On 29 June 2017 Resident O's weight is recorded as 33.6kg with instructions to reweigh tomorrow. A record is made on 30th June 2017 indicating that her weight is 47.9kg.'

The panel noted that the weight chart dated 18 July 2015 contained an entry for 30 November 2016 but thereafter recorded repeated entries of unable to weigh through to June 2017.

The panel further noted that the documentation records repeated occasions on which Resident O was said to be unable to be weighed. The panel had regard to Lucy Botting's evidence about alternative means to calculate weight where there may be difficulties in physically weighing a resident.

The panel was satisfied that there was no evidence of alternative steps being taken to obtain or record weight information during that period.

The panel was therefore satisfied that between November 2016 and June 2017, Resident O was not weighed and/or her weights were not recorded.

The panel therefore find this charge proved.

Charge 13i

i) Failed to ensure that an assessment of a wound to the right knee was undertaken and/or recorded prior to 20 July 2017

This charge is found NOT PROVED.

The panel was satisfied that Mrs Cooper had a duty to ensure that wound assessment was undertaken and recorded for any resident with a wound for the reasons already articulated in the panel's findings at charge 1.

In reaching its decision as to whether Resident O had a wound to the right knee, the panel took into account all the evidence, including the clinical notes dated 20 July 2017, the wound assessment documentation dated 11 April and 21 May 2017 and wound management charts dated 17 and 20 July 2017, references to wound care in the nursing care records dated 17 May 2017, the photographs 20 July 2017, and care plan dated 21 July 2017. The panel also took into account the evidence of Lucy Botting. The panel was satisfied that Resident O had a wound on the right knee which required a wound assessment.

In considering whether Mrs Cooper had failed in her duty, the panel noted the existence of wound assessment documentation for the wound on Resident O's right knee prior to 20 July 2017. The panel therefore was not satisfied that this charge was made out. Accordingly, the panel find this charge not proved.

Charge 13j

j) Failed to ensure that an assessment was undertaken and/or recorded for a sacral sore in 2017

This charge is found PROVED.

For the reasons given at charge 1, the panel was already satisfied that Mrs Cooper had a duty in relation to wound management, which included a duty to assess and record wounds when any resident had a wound. The panel was satisfied that this duty applied equally to a sacral sore, which is a wound.

In reaching its decision as to whether Resident O had a sacral sore in 2017, the panel considered the evidence, including Lucy Botting's evidence, the reference to applicable NICE guidance about wound management standards and pressure ulcer management, Resident O's clinical records dated 10-11 October 2017 and the earlier care plan for a sacral pressure sore dated 28 October 2015. The panel was therefore satisifed that Resident O did have a sacral sore in 2017.

In considering whether Mrs Cooper failed in her duty, the panel noted that whilst the evidence before it records dressing changes and clinical observations, there is no document before it that demonstrates an assessment of the sacral sore being undertaken and/or recorded in 2017.

On the balance of probabilities, the panel concluded that although the sacral sore existed and it required assessment, no such assessment was undertaken and/or recorded in the evidence before it.

The panel therefore find this charge proved.

Charge 13k

k) Failed to ensure that body maps were undertaken with sufficient frequency to meet Resident O's care needs

This charge is found PROVED.

The panel was already satisfied that Mrs Cooper had a duty in respect of all residents who had wounds to ensure that body maps were undertaken with sufficient frequency to meet their care needs for the reasons articulated in charge 1.

In reaching its decision as to whether Resident O had a wound which required a body map, the panel considered all of the evidence before it, which included the pre-admission documentation, the body maps between June and August 2015, the sacral sore care plan dated 28 October 2015, the wound management care plan dated 31 July 2016, and the evidence of Lucy Botting.

The panel was therefore satisfied that Resident O had wounds which required corresponding body maps.

In considering whether Mrs Cooper had failed in her duty, the panel noted that there were a number of deficiencies in the body map documentation relating to Resident O. This included certain wounds that were identified in the records having no corresponding body map, and where body maps did exist, they were often single entries only with no subsequent entries to show any progression or healing. The body maps that were available also did not consistently correlate with the wounds which were identified in the records.

For example, the panel had sight of a pre-admission form dated 7 July 2015 which noted a right heel pressure ulcer, for which there was no corresponding body map at that time or thereafter to show progression of the wound; a sacral pressure sore recorded on 28 July 2015 did not have a corresponding body map on the point of identification or thereafter to show progression of the wound. There were further body maps dated 12 July 2015, 29 June 2017, 18 July 2017

and 18 August 2017 which show a variety of wounds but do not reflect progression, deterioration or healing of the wounds identified so as to consistently map those wounds.

Taking all of this into account, the panel was satisfied that the body maps were not undertaken with sufficient frequency to meet Resident O's care needs. The panel therefore finds this charge proved.

Charge 13l(i)

l) Failed to ensure that wound care documentation for Resident O was sufficiently complete to make clear:

i) When in and around August 2017 sacral/upper back pressure ulceration developed and/or deteriorated

This charge is found PROVED.

For the reasons given at charge 1, the panel was satisfied that Mrs Cooper had a duty in relation to wound management, which included a duty to assess and record. The panel was satisfied that this duty applied equally to sacral/upper back pressure ulceration, which are wounds.

In reaching its decision as to whether Resident O had a sacral/upper back pressure ulceration which required documentation, the panel had regard to the evidence which included the body map dated 18 August 2017, the evidence of Lucy Botting, the clinical records dated 21 August 2017, 24 September 2017 and 10-11 October 2017 and the GP records dated 4 October 2017.

The panel were not provided with any evidence in relation to a sacral pressure ulceration in or around August 2017 in respect of Resident O.

The panel noted from the evidence before it that the earliest reference to the upper back area in 2017 was the body map entry dated 18 August 2017, which recorded a 'red sore pressure mark' wound type on the spine. The panel also noted a further reference on 21 August 2017 to two red marks on the spine in the nursing care notes which were also referred to by Lucy Botting:

> *'On 21st August 2017, Colleague 2 documented that there were 2 red marks on Resident O's spine. Cream was applied and she made staff aware that Resident O should be repositioned every 2 hours. No turning charts are noted to have been put in place…'*

The panel was therefore satisfied that Resident O had developed pressure ulceration on the spine, and as a consequence, Mrs Cooper had a duty to ensure that wound care documentation was accurately completed.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel noted that it did not have any evidence before it including wound assessments, care plans, photographs or other wound documentation from in or around August 2017 that would make clear where the pressure ulceration first developed and or deteriorated.

Taking all of this into account, the panel was satisfied that Mrs Cooper failed to ensure that wound care documentation in relation to Resident O's pressure ulceration was completed in a manner which made clear the development and/or deterioration of the upper back pressure ulceration. The panel therefore find this charge proved.

Charge 13l(ii)

> ii) What if any management of the pressure ulceration referred to at 13 l) i) above there was until 18 October 2017.

This charge is found PROVED.

For the reasons given at charge 13(l)(i), the panel was satisfied that Mrs Cooper had a duty in relation to the management of Resident O's pressure ulceration.

In reaching its decision as to whether Mrs Cooper had failed in her duty to ensure that wound care documentation was sufficiently clear as to the management of that pressure ulceration, the panel had regard to the evidence before it, which includes documentation identified in relation to the upper back pressure ulceration, the clinical records in October 2017 and the GP records.

The panel further noted that there was no documentation clearly setting out what if any management of the sacral/upper back pressure ulceration was undertaken prior to 18 October 2017.

The panel was satisfied, taking all of this into account, that the wound care documentation was not sufficiently complete to make clear what, if any, management of the pressure ulceration there was. The panel therefore finds this charge proved.

Charge 13m

m) On identifying that Resident O was at risk of malnutrition, failed to escalate that risk to a GP

This charge is found PROVED.

In reaching its decision, the panel took into account its findings in relation to charges 1c, 1e, 1g, 1k and 1l in respect of Mrs Cooper's duty to manage all residents' nutrition and escalate any identified risk of malnutrition to a GP.

In reaching its decision as to whether Resident O was at risk of malnutrition, the panel had

had regard to Lucy Botting's evidence, the MUST assessment and guidance dating from 23 August 2016, the weight records dating from 18 July 2015 and the GP records dating from 4 July 2015.

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

> *'On 30th November 2016 Resident O's weight was recorded as 55.7kg. Her MUST was recorded as 1 (medium risk of developing malnutrition)*

The panel also noted that Resident O was identified as being at a medium risk of malnutrition on 30 August 2016 and a high risk on 19 August 2017 on the MUST tool.

The panel was therefore satisfied that Resident O was at risk of malnutrition.
In considering its decision as to whether Mrs Cooper failed in her duty to escalate this to the GP, the panel carefully reviewed the GP records before it and found no evidence of any referral made to a GP in relation to Resident O's risk of malnutrition.

The panel therefore find this charge proved.

Charge 13(n)(i)

n) On or before 18 October 2017:

i) Failed to ensure prompt identification and/or any or adequate treatment, and/or any or adequate escalation of one or more pressure ulcers and/or open wounds.

This charge is found PROVED.

The panel was already satisfied that Resident O had one or more pressure ulcers and/or open wounds and that Mrs Cooper had a duty to ensure prompt

identification and/or treatment of these, for the reasons already articulated in charges 13(j), 13(k), 13(l)(i) and 13(l)(ii).

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel relied in particular on its earlier findings that in relation to the upper back pressure ulceration, there was no adequate assessment undertaken and/or recorded in 2017, body maps were not completed with sufficient frequency to meet Resident O's care needs and the wound documentation generally was poor and incomplete.

The panel was satisfied that these failures evidence a lack of prompt identification, inadequate treatment and inadequate escalation of one or more pressure ulcers and/or open wounds by Mrs Cooper on or before 18 October 2017.

In light of its earlier findings the panel was satisfied that the charge is proved.

Charge 13(n)(ii)

ii) Following the identification of one or more grade 4 pressure ulcers, failed to ensure that the CQC was notified of Resident O's condition.

This charge is found NOT PROVED.

In reaching its decision, the panel, having had regard to Lucy Botting's oral evidence, was satisifed that the duty to notify the CQC of pressure ulcers grade 3 or above was a duty only for the registered manager of the Home.

Therefore, the panel found this charge not proved.

Charge 13(n)(iii)

iii) Failed to ensure any or adequate treatment of dry skin and/or keratosis

This charge is found PROVED.

The panel has already found that Mrs Cooper had a duty as a registered nurse in her role as a deputy manager to ensure adequate management of any skin conditions for the reasons already articulated in 13(l), 13(k) and 13(n).

In reaching its decision as to whether Resident O had dry skin, the panel had regard to Lucy Botting's evidence indicating that Resident O had dry skin, dry legs and dry scabs. This is supported by Resident O's GP records:

> *'On 13th January 2016 Resident O was seen by the GP for her dry legs, with some oedema present…The dry legs were documented as an ongoing problem and she had currently not been using anything for these. Regular repositioning was advised…*
> *…*
>
> *She also had:*
>
> *Right and left legs dry scabs to multiple areas on shin. Right worse than left.*
> *…*
> *Upper chest dry'*

The panel was therefore satisfied on the evidence before it that Resident O had dry skin which required treatment.

The panel was not satisfied that Resident O was suffering from keratosis. The panel noted that whilst there were references made in the documentary evidence to dry skin, dry legs and dry scabs, the panel was unable to identify any

documentation in the records, GP notes or witness evidence expressly diagnosing Resident O or recording a diagnosis of keratosis.

In reaching its decision as to whether Mrs Cooper had failed in her duty to ensure that Resident O's dry skin was adequately treated, the panel noted the absence of any evidence of treatment of Resident O's dry skin. The panel therefore find this charge proved.

Charge 13(n)(iv)

iv) Failed to ensure that one or more cream application charts was completed

This charge is found PROVED.

On review of Mrs Cooper's job description, Ms Botting's evidence regarding the NMC standards of proficiency for nurses and the NMC Code, the panel found that there was a duty for Mrs Cooper as a registered nurse in her role as deputy manager to ensure that Resident O's care needs were assessed and managed. This included management of any skin conditions. The panel was satisfied that Mrs Cooper had a duty to ensure that medication administration, including the application of cream, was recorded.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel took into account its findings in relation to 13n(iii) that Resident O had skin conditions. It also had regard to Resident O's cream application chart which covered January, February, March and April 2016, Resident O's prescription records, which showed that cream was prescribed on a PRN basis, and the evidence of Lucy Botting regarding dry skin.

The panel noted that the cream application chart was incomplete. There was some recording up to around April 2016, and some limited entries, but large

sections were blank and no continued charting, despite the cream continuing to be prescribed.

The panel accepted that even where cream was prescribed on a PRN basis, there remained a duty to record its administration, or if appropriate, the reason why it was not administered. The panel was satisfied that the documentary record did not show that cream application charts were properly completed. The panel therefore find this charge proved.

Charge 13(n)(v)

v) Failed to ensure that they were repositioned 2 hourly when required or that there were records of such turns.

This charge is found PROVED.

The panel was satisfied that there was a duty on Mrs Cooper to ensure that Resident O was repositioned 2 hourly when required and that there were records of such turns for the reasons already articulated in charges 1a and 2c(i).

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel had regard to the pre-admission assessment dated 7 July 2015, which records that Resident O should be turned 2 to 4 hourly, *'full hoist only 2 bed turns'*.

It also had sight of Resident O's pressure area care plan dated 28 October 2015, where it is recorded *'regulated 2 hourly turn checks required',* which was supported by the patient summary care records from December 2015 to August 2016 recording the need for regular turning. The panel took note of the attendance input output charts dated 9 May 2017 – 10 May 2017, 19 September 2017 and 5 October 2016 – 6 October 2016 which contained turn columns that had not been completed.

The panel noted Lucy Botting's evidence, which stated:

'There is reference to Resident O requiring 2 hourly repositioning from her admission to the Home in the nursing notes:

- *In October 2015 in the pressure area (sacral area) plan, 2 hourly turns are requested as required by …*

However there appears to be no further reference to this after 2015.

There also appear to be no individualised repositioning charts to evidence that this request was ever actioned. The attendance, input and output charts have a column for "turn". This column has no entries recorded in relation to Resident O's repositioning.'

The panel was satisfied that Resident O was high risk for pressure damage and that there was a clearly recorded requirement for regular repositioning. It noted that despite this, the relevant charts contained empty turn columns and did not demonstrate that 2 hourly repositioning had taken place.

The panel was satisfied that there were inadequate records of 2 hourly turns, despite a clear requirement for them. The panel therefore found this charge proved.

Charge 13(n)(vi)

vi) Failed to ensure that one or more fluid charts was completed adequately or at all

This charge is found PROVED.

In reaching its decision on whether Mrs Cooper had a duty, the panel took into account its previous findings articulated in charge 4(a). The panel was satisfied that Mrs Cooper had a duty to ensure that one or more fluid charts were completed adequately or at all.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel had regard to the fluid balance intake and output records dated October 2016 and March 2017-October 2017.

The panel had regard to Lucy Botting's evidence regarding the importance of hydration for Resident O, including in relation to skin integrity and kidney function.

The panel noted that fluid charts existed for Resident O but they were inadequately completed. There were substantial gaps during the course of the day where no intake was recorded; there was no consistent recording that fluids had been offered and whether they were consumed or declined; urine output was often not properly recorded, and some charts recorded extremely low levels of intake without any corresponding documentation as to what action was taken.

The panel was therefore satisfied on the evidence before it that one or more fluid charts were not completed adequately or at all. The panel therefore find this charge proved.

Charge 13(n)(vii)

vii) Failed adequately or at all to ensure that fluid intake was reviewed and/or acted upon, and/or that such reviews or action were recorded

This charge is found PROVED.

In reaching its decision on whether Mrs Cooper had a duty, the panel took into account its previous findings articulated in charge 4(a). The panel was satisfied that Mrs Cooper had a duty to ensure that fluid intake was reviewed and/or acted upon, and/or that such reviews or action were recorded.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel took into account its findings and evidence relied on in relation to charge 13(n)(vi), along with the evidence in relating to Resident O's care needs.

The panel noted that the charts recorded occasions of Resident O having very low fluid intake, in some instances over consecutive days. On some days, fluid output appeared to exceed intake. The panel also noted evidence that Resident O had relevant underlying health issues, including kidney disease, and that hydration was important for both renal function and skin integrity.

The panel had no evidence, documentary or otherwise, before it demonstrating that these low levels of intake were subject to any review, action, escalation or recording.

The panel was therefore satisfied that the evidence did not support any adequate review, action, or recording of such action having taken place. The panel therefore find this charge proved.

Charge 13(n)(viii)

viii) Following weight loss, failed to ensure that Resident O was referred to a dietician

This charge is found PROVED.

In reaching it decision as to whether Mrs Cooper had a duty to ensure that Resident O was referred to a dietician, the panel had regard to its findings as set out in charge 1(c). The panel was satisfied that Mrs Cooper had a duty to ensure a referral was made to a dietician.

In deciding whether Resident O had lost weight, the panel had regard to MUST scores dated July and August 2017 and a MUST review and assessment dated 19 September 2017, along with Resident O's weight chart dated 18 July 2015

and was satisfied that Resident O had lost weight, over 15kgs. The panel was satisfied that in these circumstances, a referral to a dietician was necessary.

The panel was satisifed that there is no evidence before it of a referral to a dietician, no evidence of any request for such referral and no evidence of any follow up in relation to this. The panel therefore find this charge proved.

Charge 14

14 In relation to Resident R, on or before 17 October 2017, failed to ensure that they had a skin condition care plan in place.

This charge is found PROVED.

In reaching its decision on whether Mrs Cooper had a duty, the panel took account of its previous findings articulated at charge 1. The panel was therefore satisfied that Mrs Cooper had a duty to ensure that a resident with a skin condition had a skin condition care plan in place. The panel was also satisfied from Resident R's nursing records that they suffered with a skin condition on or before 17 October 2017.

In reaching its decision on whether Mrs Cooper failed in her duty, the panel had regard to the evidence of Elena Marin, a continuing healthcare nurse for the CCG, along with her oral evidence. The panel took into account the following extract from Elena Marin's witness statement describing her visit to the Home on 17 October 2017:

> *'… (Resident R) was admitted to the Home on 6 of October 2017 but on the day of the visit there was not a care plan in place. The discharge letter from the hospital mentioned that Resident R had chronic leg ulcers varicose eczema and recurrent cellulitis. There was no skin condition care plan in place either which would have described the skin condition and what staff interventions would have been required to maintain skin*

integrity, spot early signs of infection or ulcers reappearing and prevent skin deterioration...'

The panel found Elena Marin's evidence to be clear and compelling and in respect of Resident R's skin condition was supported by the hospital discharge letter. Her evidence was that the resident had a skin condition requiring care planning, but that no skin condition care plan was in place. The panel noted that this was also consistent with her oral evidence, in which she reiterated that there was in fact no care plan at all in place for that issue.

On the evidence before it, the panel was satisfied that Resident R had a skin condition requiring care planning, and that no such care plan was put in place. Accordingly, the panel finds this charge proved.

Charge 15

15 In relation to one or more Residents, requiring a pressure mattress, failed adequately or at all to ensure that there was a monthly audit to affirm that the mattress was at the correct setting for their weight and body mass index.

This charge is found PROVED.

In reaching its decision as to whether Mrs Cooper had a duty to ensure that there was a monthly audit of pressure mattresses, the panel had regard to its earlier findings in relation to charges 1n(i) and 13(b). The panel was satisfied that Mrs Cooper had such a duty.

In reaching its decision as to whether Mrs Cooper had failed in her duty, the panel noted that it had already found that there was insufficient evidence to establish that there were systems in place to ensure that pressure mattresses were functioning correctly and set appropriately, including by reference to the resident's weight and their body mass index.

The panel was satisfied that the reasoning underpinning its finding on charge 13(b) also applied in relation to charge 15. It considered that the evidence, including documentary evidence, does not support a monthly audit being conducted to demonstrate that the mattress was at the correct setting for their weight and body mass index

Accordingly, and for the same reasons as set out in relation to charges 1n(i) and 13(b), the panel finds this charge proved.

Charge 16

16. In relation to one or more Residents, failed adequately or at all to ensure that call bells would be answered promptly and/or in under 20 minutes and/or 10 minutes.

This charge is found PROVED.

In reaching its decision as to whether Mrs Cooper had a duty to ensure that call bells would be answered promptly and/or in under 20 minutes and/or 10 minutes, the panel had regard to Mrs Cooper's job description. It noted that the job description included responsibilities for providing a safe and secure environment for residents. The panel was satisfied that an integral part of these responsibilities was to ensure that call bells would be answered promptly. This is in line with the witness statement evidence of Stephanie Patience, which states that *'whilst there is no specific timeframe or policy for this, we would expect call bells to be answered in a short timeframe because staff would need to ascertain why someone was calling.'* The panel was therefore satisfied that Mrs Cooper had a duty to ensure that call bells would be answered promptly, and so there was no need for the panel to consider a specific time frame.

In reaching its decision as to whether Mrs Cooper failed in her duty, the panel had regard to the evidence of Elena Marin, including her oral evidence and the CCG action plan dated 9 November 2017.

The panel noted that the CCG action plan referred to the implementation of weekly review of call bell response times, which indicated that this was already an identified area of concern.

The panel also considered the oral evidence of Elena Marin which was consistent and corroborative of the documentary evidence before the panel. In particular, she described a specific occasion when the wife of a resident drew her attention to a call bell that had gone unanswered for approximately 50 minutes.

The panel was satisfied on the balance of probabilities that this evidence taken as a whole demonstrated that one or more residents' call bells were not being answered promptly.

Accordingly, the panel finds this charge proved.

Charge 17

17. On or about 27 October 2017, in an email to the CQC, made one or more of the following representations directly or indirectly, which were not accurate:
a) In total, 2 Residents had pressure sores
b) Adequate care planning was in place for the Residents with pressure sores
c) Pressure mattresses for Residents with pressure sores had been set correctly
d) You had ascertained the matters at charges 2 a)-c) above by carrying out checks yourself

This charge is found PROVED (in respect of 17(a), 17(b) and 17(c))

This charge is found NOT PROVED (in respect of 17(d))

In reaching its decision, the panel had regard to the email correspondence dated 27 October 2017 between Margaret Cooper and Stephanie Patience, the witness statement evidence of Stephanie Patience and the CQC email to the CCG dated 18 November 2017 showing the position identified on inspection. It noted that Stephanie Patience's evidence was hearsay. However, it was consistent with the documentary evidence before the panel, came from a reliable source and was not sole or decisive.

The panel noted that in the email of 27 October 2017, Mrs Cooper identified only two residents as having pressure ulcers, Residents AD and A, and represented that those were the only residents with pressure ulcers then known to the Home.

The panel took account of the email between the CQC and the CCG dated 1 November 2017 which confirmed Residents A, C, AC, AD, and E were identified as having pressure sores during the CQC inspection.

The panel was satisfied that Mrs Cooper's representation in her email of 27 October 2017 was inaccurate. The evidence before the panel, including Stephanie Patience and Steven Abbott's evidence, showed that when an inspection took place on 30 October 2017, more than two residents were identified as having pressure sores.

The panel was therefore satisfied that the representation that only two residents had pressure sores was inaccurate.

Accordingly, the panel finds this limb (a) proved.

The panel then moved on to consider 17(b) and 17(c) as they are inextricably linked.

The panel considered from the evidence before it whether adequate care planning was in place for the residents with pressure sores, and that the pressure mattresses had been set correctly.

In this regard, the panel noted that charges 17(b) and 17(c) referred to 'residents with pressure sores' and the evidence before the panel, for that point in time is that

Residents A, C, AC, AD and E all had pressure sores. The panel was of the view that in considering these charges it would be sufficient if there was evidence of inadequate care planning and pressure mattresses were not set correctly for one or more of the residents that had pressure sores for Mrs Cooper's statements to be inaccurate.

In respect of charge 17(b), the panel had regard to its findings in respect of Resident C at charges 3(c), 3(d), 3(l)(ii) and 3(l)(iii) and Resident E at charge 5(a). It also took account of the email from the CQC to the CCG dated 1 November 2017. Therefore, the panel was satisfied that the statement detailed in charge 17(b) was inaccurate.

In respect of charge 17(c), the panel had regard to its findings in respect of Resident A at charge 1(n)(i). Therefore, the panel was satisfied that the statement detailed in charge 17(c) was inaccurate.

In respect of charge 17(d), the panel had sight of the email correspondence between Stephanie Patience and Mrs Cooper dated 27 October 2017, in particular Stephanie Patience's request to provide *'Confirmation that you have checked everyone using the service to ensure they do not have any pressure ulcers you are unaware of.'*

The panel noted Mrs Cooper's reply *'All Service users in our care have been checked...'*

The panel was therefore satisfied that the email correspondence demonstrates that Mrs Cooper did not make representations that she had personally carried out the checks. The panel therefore finds this limb of the charge not proved.

Charge 18a

18. One or more of your representations at charges 2 above was dishonest and/or lacked candour in that:
a) You were representing as accurate information which you knew was not or may not be accurate

This charge is found PROVED

The panel had regard to the email sent on 27 October 2017 in reply to the CQC email of the same date. The panel also had regard to Mrs Cooper's statement sent to the NMC on 3 July 2025.

> *'[Stephanie Patience] rang at 3.45pm asking me to assure her that there were no new pressure sores, as I was confident that everyone would be checked by the end of the day and I was sure there were no more open wounds I said yes… I passed over checking the remaining residents to the Night team who if I remember correctly were a Health care assistant short, so one trained Nurse and 2 HCAs instead of 3 HCAs… I didn't check in with them which with hind sight I should have done as when I arrived at work on Monday morning the remaining 7 residents hadn't been checked because of low staffing levels*.' [sic]

The panel found that, at the time Mrs Cooper represented that all residents had been checked, she knew that they had not all been checked. She was therefore representing as accurate, information which she knew was not, or may not be, accurate.

The panel applied the test in *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club) [2017] UKSC 67*. It found that Mrs Cooper knew that all residents had not been checked at the point when she represented that they had been. Mrs Cooper knew her representation to be false. The panel was satisfied that ordinary decent people would regard it as dishonest for Mrs Cooper to state that checks had been completed when she knew they had not.

Accordingly, the panel finds Charge 18(a) proved in terms of dishonesty.

Charge 18b

b) You were representing that you had carried out checks which you had not carried out, and/or did not make clear that you had not carried out checks yourself

This charge is found NOT PROVED

In considering whether Mrs Cooper had represented that she had personally carried out the checks, and/or failed to make clear that she had not carried them out herself, the panel had regard to its findings at charge 17(d). Therefore, the panel 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 Mrs Cooper's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

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

Submissions on misconduct

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

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

Ms Jones identified the specific, relevant standards where Mrs Cooper's actions amounted to misconduct. She submitted that whilst a breach of the NMC Code does not automatically amount to misconduct, in this case, Mrs Cooper's conduct represented a serious departure from the standards expected of a registered nurse, and therefore amounted to misconduct.

Submissions on impairment

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

Ms Jones submitted that it is the NMC's position that Mrs Cooper's fitness to practise is currently impaired. She submitted that remediation is a central consideration in this case, and that there is no evidence before this panel to demonstrate that Mrs Cooper has remediated the concerns identified.

Ms Jones submitted that Mrs Cooper has not demonstrated meaningful insight into the failings found proved by the panel, and had not provided recent reflective pieces, testimonials or evidence of relevant training. She further submitted that Mrs Cooper has not attended the substantive hearing, despite its lengthy duration, and that there had been no admissions to the charges. Ms Jones submitted that whilst Mrs Cooper is entitled to deny the allegations and is under no obligation to admit them, the absence of any engagement means that there is no evidence before this panel of a change in mindset or attitude.

Ms Jones submitted that, in the absence of any evidence from Mrs Cooper, the panel cannot be satisfied that the behaviour found proved would not be repeated in the future. She submitted that any concerns regarding the risk of repetition could not be alleviated because the panel has no evidence upon which to conclude that Mrs Cooper has reflected on, understood or addressed the failings. Ms Jones submitted that therefore remains a real risk that similar conduct could be repeated.

Ms Jones submitted that practising kindly and safely are fundamental and core components of the nursing profession. She submitted that the numerous clinical failings found proved by the panel demonstrate that Mrs Cooper has not practised in accordance with these fundamental principles.

Ms Jones reminded the panel that nurses occupy positions of privilege and trust within society and are expected at all times to act professionally whilst carrying out their duties effectively, efficiently and safely. She submitted that patients and their families must be able to place their trust in registered nurses. She also reminded the panel of the NMC's overarching objectives to protect, promote and maintain the health, safety and wellbeing of the public, and to uphold and protect the wider public interest.

Ms Jones submitted that, in the absence of evidence demonstrating remediation or reduced risk, there remained a real risk that Mrs Cooper could act in a similar manner in the future. She submitted that an informed member of the public would be concerned if findings of misconduct and current impairment were not made in a case involving such wide-ranging clinical concerns. Ms Jones invited the panel to find that Mrs Cooper's conduct amounted to misconduct and that her fitness to practise is currently impaired.

The panel heard and accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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 Mrs Cooper's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Cooper'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*
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2.1** work in partnership with people to make sure you deliver care effectively*
>
> ***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*
> ***3.2** recognise and respond compassionately to the needs of those who are in the last few days and hours of life*
> ***3.4** act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*
>
> ***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*
>
> ***10.1** complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> ***10.2** identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

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

13.1 *accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*
13.2 *make a timely referral to another practitioner when any action, care or treatment is required*
13.3 *ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*

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

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

20.1 *keep to and uphold the standards and values set out in the Code*
20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

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

The panel considered each proved charge individually, aside from a number of charges which raised the same issue or concerned repeated failings of a similar nature, where the panel decided to consider them together in order to avoid repetition and in the interests of reaching a rational and reasonable decision.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Cooper's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct, and made the following findings in respect of each proved charge:

Charge 1a

The panel was of the view that charge 1a amounted to misconduct. In reaching its decision, the panel considered that maintaining complete repositioning records for a vulnerable resident was a fundamental aspect of safe nursing care.

The panel noted its previous findings at the facts stage demonstrated significant gaps in repositioning records over a prolonged period. This was not an isolated incident. The panel also took into account that Resident A was elderly, particularly vulnerable to skin damage and already had compromised skin integrity. It concluded that repositioning was integral to Resident A's care needs, health, dignity and comfort.

The panel considered that Mrs Cooper, as a registered nurse in her role as Deputy Manager, had responsibility for ensuring that effective systems were in place to ensure that repositioning was both carried out and appropriately documented. In light of the prolonged nature of the failure, Resident A's vulnerability and Mrs Cooper's nursing and deputy management responsibilities, the panel determined that this represented a serious departure from the standards expected of a registered nurse and therefore amounted to misconduct.

Charges 1b, 1d, 1f, 1h and 1j

The panel considered these charges together, as each sub charge concerns failures to ensure that an individual wound care plan was put in place following identification of a wound/wounds. The panel noted that these sub charges relate to failures to put in place wound care plans for Resident A on five dates spanning the period from 5 March 2017

to 26 July 2017. The panel took into account that on all of these dates, either broken skin or wounds had been identified on Resident A.

The panel was satisfied that these failures represented poor nursing practice over a significant time period and breached the standards expected of a registered nurse under the NMC Code. The panel also determined in the circumstances that the breaches were serious and amounted to misconduct.

Charges 1c, 1e, 1g, 1k and 1l

The panel considered these sub charges together as each concern a failure to ensure that an appropriate dietetic referral and/or GP review took place following significant weight loss in Resident A, who was elderly and vulnerable.

The panel noted that the threshold requiring a dietetic referral had been reached in each instance and was of the view that this is a fundamental aspect of nursing care.

The panel considered that repeated failures to ensure a dietetic referral for a resident experiencing significant weight loss exposed Resident A to a risk of deterioration in their health and demonstrates a failure to respond appropriately to the clinical needs of the resident. The panel also noted Mrs Cooper's deputy managerial responsibilities within the Home.

For those reasons, the panel determined that charges 1c, 1e, 1g, 1k and 1l, as found proved, amounted to misconduct.

Charge 1i

The panel determined that charge 1i amounted to misconduct. It noted that Resident A had been prescribed nutritional supplements on 14 July 2017 due to their weight loss, and once these had commenced, it was important that an adequate dietetic or nutritional plan was put in place to ensure that Resident A's nutritional needs were being managed appropriately.

The panel was of the view that the absence of an adequate dietetic or nutritional plan is a serious breach of nursing standards, because Resident A was elderly, vulnerable and had experienced significant weight loss.

The panel considered Resident A's vulnerability along with the fact that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager within the Home and concluded that its findings at charge 1i amounted to misconduct.

Charge 1n(i)

The panel considered whether the failure to adequately ensure that the pressure mattress was set to the correct weight amounted to misconduct. It was of the view that this does amount to poor nursing practice. However, this charge identifies an isolated failure in relation to the mattress setting, and the panel did not consider this, in isolation, to be sufficiently serious as to amount to misconduct. The panel therefore did not find that this charge amounted to misconduct.

Charge 1n(ii)

The panel determined that charge 1n(ii) amounted to misconduct. This sub charge was in relation to a failure to ensure that any or an up-to-date wound care plan was in place in relation to one or more wounds.

The panel considered that a number of failures in relation to wound care planning in respect of Resident A had been proved. The panel further considered that taking these failings together, there were multiple wounds which did not have wound care plans. The panel therefore determined that this was not an isolated incident and reflected a significant failure in relation to Resident A's care.

Taking all of this into account, along with Resident A's vulnerabilities and that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager, the

panel reached the conclusion that this failure was a serious departure from the standards expected of a registered nurse and therefore amounted to misconduct.

Charge 1n(iii)

The panel considered that the absence of a care plan to manage the risk of Resident A's choking exposed the resident to potentially life-threatening consequences.

The panel noted that Resident A had swallowing difficulties and required an appropriate care plan to ensure safe management of that risk. It therefore considered that the absence of such care plan involved a fundamental aspect of safe nursing care and, given that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager, amounted to misconduct.

Charge 1n(iv)

The panel considered that the failure to ensure that any or an up-to-date care plan to help Resident A attain a healthy weight was in place was fundamental in the circumstances given that Resident A had already experienced significant weight loss.

The panel was of the view that the context of Resident A's condition and the absence of any up-to-date care plan, represented a serious failure by Mrs Cooper to manage an identified clinical risk and amounts to misconduct.

Charge 1n(v)

The panel noted from its previous findings that Resident A had lost approximately 15 kilograms between February and October 2017 and that there was no adequate care plan in place setting out how the resident's nutritional intake should be supported. The panel was of the view that the failure to monitor food intake represented a serious omission.

The panel considered that ensuring that Resident A's food intake was being monitored is an essential aspect of managing their care, especially in the context of Resident A who had significant weight loss and had been prescribed nutritional supplements. It therefore determined that the findings in this charge amount to misconduct, given that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager.

Charge 1n(vi)

The Panel considered that preventative measures should have been taken to ensure that Resident A's low weight did not lead to skin damage. It was of the view that this demonstrated failures across several fundamental aspects of nursing practice, including nutritional management, pressure area care and skin integrity.

The panel considered the serious consequences which could arise from failing to prevent skin breakdown in an already vulnerable resident. Given that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager, the panel concluded that this represented a serious departure from the standards expected of registered nurses and amounted to misconduct.

Charge 2a

The panel considered Charge 2a, which concerned the failure to ensure that an assessment took place and/or a wound care plan was in place in relation to a wound on Resident B's left shin. It determined that, as per its previous approach to individual missing wound care plans in relation to Resident A, this failure was not sufficiently serious, when viewed individually, to amount to misconduct.

Charge 2b (in its entirety)

The panel had regard to the range of sub charges and its findings of facts, all but one of which the panel found proved.

The panel had regard to Resident B's circumstances, including that Resident B was elderly, immobile and had advanced dementia. The panel considered that Resident B was a vulnerable adult and required a comprehensive care package.

The panel considered that failures, including a failure to include a PEEP, continence care plan, Waterlow risk assessment, MUST risk assessment and records of bruising were serious because they amounted to failures in fundamental aspects of care.

For example, the panel considered that without a PEEP in place, if evacuation had been required, staff would not have had adequate instructions as to how Resident B should be safely evacuated, with potential life-threatening consequences.

The panel also had regard to the fact that Resident B had continence needs relating to both urinary and bowel care, and had a catheter in place. The panel noted the risks, including potential for infection and life-threatening sepsis, which could stem from poor record keeping around catheter management. The panel determined that continence and catheter management formed a significant part of Resident B's care needs.

The panel further considered that MUST documentation was an important tool for assessing and monitoring nutritional status and associated risks. It noted its previous findings that Resident B required significant support with nutrition, and the absence of any or adequate MUST documentation meant that there was no robust baseline or monitoring tool to guide care.

The panel also considered that unexplained bruising is a safeguarding concern. The absence of records as to how bruising identified in June and August 2017 had occurred meant that there was no record of any investigation undertaken, explanation for the bruising or action taken.

The panel found that these failures to ensure that Resident B's care records were complete were sufficiently serious to amount to misconduct, in that they breached fundamental aspects of Resident B's care needs.

Charge 2c(i)

The panel then considered Charge 2c(i), which concerned the failure to ensure that Resident B was turned two-hourly and/or that two-hourly turns were recorded.

The panel noted that Resident B was highly vulnerable, immobile, bedbound and unable to reposition themselves. Resident B was also at high risk of pressure ulcers.

The panel noted that the records before it were inconsistent and irregularly completed, with significant periods of time where there were no records. It considered that this exposed Resident B to a risk of serious harm. The panel was of the view that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager, and that their conduct fell seriously below the standards expected of a registered nurse and amounted to misconduct.

Charge 2c(ii)

The panel considered Charge 2c(ii), which concerned the failure to ensure that a care plan was in place to ensure that staff fed Resident B safely.

The panel noted from its previous findings that Resident B was at risk of choking and aspiration, and that Resident B had longstanding vulnerabilities in relation to safe consumption of food. It had regard to evidence that food lumps represented a choking risk and that staff required clear guidance in the form of a care plan, in relation to Resident B’s food consumption, including around positioning.

The panel considered that the potential serious consequences of unsafe food consumption included choking. The panel concluded that this failure fell seriously below the standards expected of a registered nurse and amounted to misconduct.

Charge 2c(iii)

The panel considered Charge 2c(iii), which concerned the failure to ensure that a nutrition care plan and/or food intake monitoring was in place.

The panel noted from its previous findings that Resident B had significant nutritional needs, issues with swallowing, had been seen by a dietician, and was very underweight.

The panel considered that, in the context of Resident B's needs, a nutrition care plan and/or food intake monitoring were essential. It further considered the potential serious consequences if nutrition and food intake were not properly monitored and reviewed for Resident B. The panel also took account of the period of time over which these concerns existed and Mrs Cooper's responsibility as a registered nurse in her role as deputy manager. The panel concluded that Charge 2c(iii) amounted to misconduct.

Charge 3a

The panel first considered Charge 3a, which concerned the failure to ensure that there was a monthly weight chart in Resident C's clinical records. The panel noted that Resident C was being weighed monthly and that MUST documentation had been completed. It therefore considered that, although the absence of a monthly weight chart was poor practice, the relevant risk was being managed in substance. In the circumstances, the panel determined that Charge 3a was not sufficiently serious to amount to misconduct.

Charge 3b

The panel then considered Charge 3b, which concerned the failure to ensure that there was a wound management plan in place following identification of inflammation around Resident C's catheter.

The panel noted from its previous findings that there was a catheter care plan in place. It considered that whilst a separate wound management plan would have been good

practice, in the context of the existing catheter care plan, the absence of a supplemental wound care plan was not sufficiently serious to amount to misconduct.

Charge 3c

The panel considered Charge 3c, which concerned the failure to ensure that there was a wound assessment and/or wound care plan following identification of a pressure sore on or about 5 December 2016.

The panel noted from its previous findings that this was an established pressure sore which had been identified and documented. There was no evidence that a wound assessment had taken place, nor that a wound care plan had been put in place. The panel considered evidence that pressure sores can deteriorate rapidly and have serious consequences if not properly assessed, planned for and managed.

The panel was of the view that the absence of appropriate documentation also meant that it was difficult to establish whether later pressure damage was the same wound or a different wound. The panel concluded that this failure was serious and amounted to misconduct as it created a significant risk to Resident C. The panel was of the view that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager, and that their conduct fell seriously below the standards expected of a registered nurse.

Charge 3d (in its entirety)

The panel considered Charge 3d, which concerned the application of a dressing to a pressure sore on or about 12 March 2017.

The panel noted that there was no adequate wound assessment or wound care plan, no body map, and no clarity as to whether this was the same pressure sore previously identified. Given the seriousness of pressure sores and the need for clear assessment, care planning and monitoring, the panel concluded that its findings in relation to Charge 3d amounted to misconduct.

Charges 3e and 3f

The panel considered that these charges related to failures following identification of a burst blister and two skin tears, and that these failures represented poor nursing practice.

The panel however considered that when viewed individually, these isolated failures did not cross the threshold of seriousness to amount to misconduct.

Charge 3g

The panel considered that the failure to ensure that Resident C's room was cleaned frequently represented poor nursing practice and a departure from the expected standards.

The panel however was not satisfied based on the evidence before it that this failure reached the threshold of seriousness in order to amount to misconduct.

Charge 4a

The panel considered Charge 4a, which concerned the failure to ensure that one or more fluid intake charts was fully completed. The panel determined that this amounted to misconduct.

The panel had sight of evidence in relation to Resident D's history of urinary tract infections and blood tests showing dehydration. It noted that the inadequate recording took place over a lengthy period, from around 22 February to 31 October 2017.

The panel considered its previous findings that fluid intake monitoring is particularly important for elderly and vulnerable residents, and especially for a resident with dehydration and recurrent UTIs. The panel was of the view that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager, and that their

conduct fell seriously below the standards expected of a registered nurse and amounted to misconduct.

The panel concluded that the failures found in Charge 4a were sufficiently serious to amount to misconduct.

Charge 4b

The panel considered Charge 4b, which concerned repositioning records. The panel noted the importance of repositioning records and the potential risks associated with poor record keeping in relation to elderly, vulnerable residents. The panel noted the significant gaps in record keeping for Resident D and was satisfied that this amounted to a serious failing constituting misconduct.

Charges 4c(i) and 4c(ii)

The panel considered the facts found proved in Charge 4c(i) and 4c(ii), which concerned the absence of a pressure area care plan and a wound care plan for one or more wounds on Resident D's arms.

The panel considered that there was evidence before it of some care planning for wounds on Resident D's arms and there was no evidence of Resident D having developed a pressure ulcer. The panel found that the failure to include these care plans in Resident D's records was poor practice, but not sufficiently serious to amount to misconduct.

Charge 5a

The panel took into account its earlier findings that Resident E had an established pressure sore over a period of approximately one month, yet there was no care plan in place.

The panel considered that a pressure sore requires proper assessment and monitoring due to the associated risk of deterioration and potential serious harm. The panel was of the view that the failure to ensure that a care plan was in place for a pressure sore represents a serious departure from the standards expected of a registered nurse and amounts to misconduct.

Charge 5b

The panel took into account its findings in respect of charge 5a above. It considered that Resident E required measures in place to prevent further skin breakdown where there was already an identified pressure sore.

The panel was of the view that the failure to ensure that measures were in place to prevent further skin breakdown was serious due to the potential for further deterioration and serious harm and fell far below the standards expected of a registered nurse. The panel determined that its findings in respect of this charge were sufficiently serious to amount to misconduct.

Charge 6a

The panel noted from its earlier findings that Resident F had dementia and required support and encouragement with fluid intake. The panel considered that there were incomplete and inconsistent records over a prolonged period, and it was unclear whether Resident F had insufficient hydration or whether intake had not been recorded.

The panel considered that ensuring that Resident F had sufficient hydration and that this was clearly recorded were fundamental aspects of nursing care for a vulnerable resident. It was of the view that the failure to ensure clarity in the records exposed Resident F to a risk that they had insufficient hydration or that their intake was not accurately recorded and concluded that its findings in respect of charge 6a were sufficiently serious to amount to misconduct.

Charge 6b

The panel considered that the failure to ensure that a pressure area care plan was in place represented poor nursing practice but did not meet the threshold of seriousness to amount to misconduct.

Charge 6c

The panel noted from the evidence before it that Resident F had a history of anorexia, was under the care of a dietitian, had a MUST score of 2 and was at high risk of malnutrition. The care plan recorded that, because of cognitive impairment and dementia, Resident F could forget to eat and drink and required prompting and encouragement.

The panel considered that the failure to ensure assistance was given for Resident F to feed was a serious failing in the context of Resident F's particular needs, and providing assistance with feeding is a fundamental aspect of safe and compassionate care for this resident which would have been expected of a registered nurse. It therefore concluded that its finding in relation to charge 6c were sufficiently serious as to amount to misconduct.

Charge 6d(i)

The panel noted from its fact findings that Resident F was at high risk of pressure sores and had a high Waterlow score, with discoloration to the sacrum having been identified on 20 September 2017.

The panel considered the evidence before it of the inherent risks of pressure sores to vulnerable residents. It took into account that discoloration was identified on Resident F's sacrum on 20 September 2017 and they had not been checked for a pressure sore since that date. The panel considered that this was a serious departure from the standards expected of registered nurses and amounted to misconduct.

Charge 6d(ii)

The panel considered that this charge was closely linked to charge 6d(i). Given Resident F's high risk of pressure sores and the identified discoloration to the sacrum, measures to prevent further skin breakdown were required. It was therefore of the view that the failure to ensure such measures were in place exposed Resident F to a serious risk of harm.

The panel concluded that its findings in relation to charge 6d(ii) were sufficiently serious to amount to misconduct.

Charge 8a

The panel considered Charge 8a, which concerned the failure to ensure that Resident I had adequate fluid intake and/or that fluid intake was recorded correctly.

The panel applied similar reasoning as per its earlier decision in relation to Charge 4a. It noted from the evidence before it that Resident I had a history of frequent urinary tract infections, with references in the records over a significant period. The panel considered that this was a known and consistent risk, and was not an isolated issue. In those circumstances, the panel was of the view that accurate fluid monitoring was important to Resident I's care and clinical safety. The panel concluded that a failure to do so was a serious departure from the standards expected from a registered nurse and was sufficiently serious as to amount to misconduct.

Charge 8b

The panel considered Charge 8b, which concerned the failure to ensure that a care plan for urinary tract infections was in place.

The panel noted from its previous findings that Resident I had a long history of UTIs, with records referring to this as early as 2012 and continuing to 2017. The panel considered that the risk was well known and that the consequences of failing to plan for recurrent UTIs could be serious and represented a departure from the standards

expected of a registered nurse. The panel was of the view that Mrs Cooper had a responsibility as a registered nurse in her role as deputy manager, and that her conduct fell seriously below the standards expected of a registered nurse and amounted to misconduct. The panel concluded that its findings in relation to Charge 8b amounted to misconduct.

Charge 10a

The panel considered Charge 10a, which concerned the failure to ensure that one or more wounds were described in a wound assessment chart, body mapped and/or photographed.

The panel had regard to its findings in relation to the number of wounds and injuries identified, including cuts, scratches, bleeding, unwitnessed falls with head injuries, facial injuries, elbow bleeding and sore shoulders. These occurred over a prolonged period, including December, January, March, May, August and September 2017. The panel considered this to be a consistent failure to assess, record and monitor wounds over time.

The panel also had regard to Resident K's circumstances, including their dementia, psoriasis and history of falls. Resident K was therefore at increased risk of skin damage and injury. The panel considered that the absence of proper wound assessment, body mapping and photographic evidence made it difficult to monitor wounds, identify deterioration or ensure appropriate treatment, and fell far below the standards expected of a registered nurse. The panel therefore concluded that its findings in Charge 10a were sufficiently serious as to amount to misconduct.

Charge 10b

The panel considered Charge 10b, which concerned the failure to ensure that a referral to a dietician was made following weight loss of approximately 10kg since admission.

The panel had regard to its findings of fact in relation to the significant weight decline over a prolonged period from January 2016 to September 2017. It considered that a referral to a dietician was a fundamental aspect of Resident K's nursing care.

The panel considered that the failure to ensure a dietetic referral for a resident experiencing significant weight loss exposed Resident K to a risk of deterioration in their health and demonstrates a failure to respond appropriately to the clinical needs of the resident.

The panel concluded that its findings in charge 10b were sufficiently serious to amount to misconduct.

Charge 13a

The panel considered its findings of facts at charge 13a, which concerned the failure to ensure that Resident O was weighed, or that weights were recorded, on admission and/or prior to December 2015.

The panel noted from its findings that Resident O was admitted to the Home in July 2015 and that their weight was not recorded until December 2015, meaning that there was no baseline weight from which staff could accurately monitor Resident O's nutritional status.

The panel considered that weighing a frail and vulnerable resident, and accurately recording their weight on admission and at appropriate intervals, was a fundamental assessment from which other aspects of care planning and risk assessment flowed. The panel concluded that the failure to establish and record this baseline was sufficiently serious to amount to a finding of misconduct.

Charge 13b

The panel considered its findings of fact in relation to Charge 13b, which concerned the failure to ensure that a pressure mattress, put in place on or around 27 October 2015,

was checked regularly to ensure that it was working and at the correct setting, or that there were adequate records of such checks.

The panel distinguished this from a single failure to set a pressure mattress to the correct weight. It considered that charge 13b concerned an ongoing failure to ensure regular checks and adequate records, and took account of its earlier findings that Resident O was highly vulnerable to pressure damage and had been seen by the TVN.

The panel considered that a pressure mattress was an essential preventative measure, and that a mattress set incorrectly or not working properly could worsen skin damage. The panel also had regard to the serious outcome for Resident O. In those circumstances, the panel concluded that the ongoing failure to check and record the mattress setting was a serious departure from the standards expected of a registered nurse, and was sufficiently serious to amount to misconduct.

Charge 13d

The panel considered its findings of fact in relation to Charge 13d, which concerned the socialisation care plan. The panel took into account that there was a care plan in place for Resident O, however it was not adequately personalised and/or signed by Resident O.

However, the panel was satisfied that this was poor practice, rather than a failure sufficiently serious to amount to misconduct.

Charge 13e

The panel considered its findings in relation to charge 13e, which considered whether adequate stimulation was recorded for Resident O. The panel noted evidence before it that the activity charts of Resident O were only partially completed with periods of time when there were no records of the activity stimulation provided.

The panel considered that whilst the failure to ensure that any or adequate activity stimulation was recorded is poor practice, it is not sufficiently serious to meet the threshold to amount to misconduct.

Charge 13h

The panel considered that the failure to ensure that Resident O was weighed and/or that weights were recorded between November 2016 and June 2017 took place over a long period of time, during which Resident O's weight decreased significantly, from 55.7kg to 33.6kg.

The panel noted that, where Resident O was recorded as "unable to weigh", no adequate alternative steps were taken to calculate weight. It considered that Resident O's weight was fundamental to monitoring nutrition, skin integrity, pressure area care and the correct setting of a pressure mattress. In the context of Resident O's vulnerability and significant deterioration, the panel was of the view that this failure was sufficiently serious to amount to misconduct.

Charges 13j, 13k, 13l(i) and 13l(ii)

The panel considered Charges 13j, 13k, 13l(i) and 13l(ii) together. The panel considered these charges together, as each sub charge concerns failures relating to wound management and recording. The panel noted that these sub charges relate to failures between July and October 2017 in relation to the same resident. They concerned the failure to assess or record a sacral sore, the failure to undertake body maps with sufficient frequency, and the failure to ensure sufficiently complete wound care documentation.

The panel noted from its earlier findings that Resident O was vulnerable to repeated pressure sores, some of which required involvement from the TVN. The panel considered that body mapping and wound documentation were fundamental to assessing, monitoring and managing wounds. Without adequate records, staff could not

properly assess how wounds developed, whether they were worsening, or what treatment was required, placing Resident O at risk of serious harm.

The panel considered that there were serious potential consequences of unmanaged pressure sores, and that these failures were individually and collectively sufficiently serious to amount to misconduct.

Charge 13m

The panel considered its findings in relation to charge 13m. The panel had regard to Resident O's significant weight decline over a prolonged period and that escalation was a necessary step in managing nutritional risk. The panel was of the view that this failure to escalate this risk to the GP fell far below the standards expected of a registered nurse, placed Resident O at risk of serious harm and was sufficiently serious to amount to misconduct.

Charge 13n(i)

The panel considered its findings in relation to charge 13n(i), which concerned failures to ensure prompt identification, adequate treatment and/or escalation of pressure ulcers and open wounds.

The panel was of the view that these failures fell far below the standards expected of a registered nurse, placed Resident O at risk of serious harm and were sufficiently serious to amount to misconduct.

Charge 13n(iii)

The panel considered its findings of fact in relation to this charge, which concerned the failure to ensure adequate treatment of dry skin in relation to Resident O. The panel noted that this was an extensive dry skin problem, which had required GP input and prescriptions, and that Resident O was at high risk of developing wounds and had impaired skin integrity.

The panel considered that treatment of the dry skin was fundamental both to skin integrity and to Resident O's care needs. The failure to ensure adequate treatment of dry skin was incompatible with the fundamentals of nursing care, and the standards expected of a registered nurse, and therefore sufficiently serious as to amount to misconduct.

Charge 13n(iv)

The panel considered its findings of fact in relation to the failure to ensure that cream application charts were completed and noted that the prescribed cream formed a fundamental part of Resident O's treatment regime.

The panel considered that the failure to complete the charts meant there was no adequate record that prescribed treatment was being delivered to manage Resident O's skin condition and symptoms, which placed Resident O at risk of harm. It was of the view that failure to ensure this was incompatible with the fundamentals of nursing care, and the standards expected of a registered nurse, and therefore sufficiently serious as to amount to misconduct.

Charge 13n(v)

The panel considered its findings of fact that Resident O was highly vulnerable to pressure sores. It took account of the evidence that the failure to ensure that Resident O was repositioned 2 hourly when required or that there were records of such turns continued over a long period between October 2016 and May 2017. It considered that this placed Resident O at risk of serious harm. The panel was of the view that this concerned a pressure area prevention measure which forms part of the fundamentals of nursing care and fell short of what would have been expected of a registered nurse. The panel found that these failures were sufficiently serious as to amount to misconduct.

Charges 13n(vi) and 13n(vii)

The panel considered its findings of fact in respect of the failures relating to fluid charts, fluid intake review and action. It noted that the lack of recording extended over approximately a year, from October 2016 to October 2017. The panel considered that hydration was fundamental to Resident O's health, including their skin integrity. This was significant given their vulnerability to pressure damage and skin breakdown. The panel was of the view that this failure placed Resident O at risk of serious harm, fell far below the standards expected of a registered nurse and was sufficiently serious as to amount to misconduct.

Charge 13n(viii)

The panel considered its findings of fact in relation to the failure to refer Resident O to a dietician following weight loss and applied the same reasoning as for Charge 13h and the other failures in respect of nutritional management. The panel noted that Resident O had lost a significant amount of weight over time, and referral to a dietician was a fundamental aspect of their care.

In the context of Resident O's vulnerability and significant deterioration, the panel was of the view that this failure placed Resident O at risk of serious harm and was sufficiently serious to amount to misconduct.

Charge 14

The panel considered its findings of fact that Resident R had established skin conditions, including varicose eczema and cellulitis, which required management. It also considered that the absence of a skin condition care plan meant there was no adequate assessment or plan to manage the conditions or prevent deterioration, and placed Resident R at risk of serious harm.

The panel was of the view that this amounted to neglect of an existing health condition, fell far below the standards that would be expected of a registered nurse, and was sufficiently serious to amount to misconduct.

Charge 15

The panel considered its findings of fact in relation to charge 15 and applied similar reasoning as per its findings set out in Charge 13b.

The panel considered that this was not a single isolated mattress-setting failure, but a failure in the system for checking pressure mattresses for residents who required them. It considered that pressure mattresses were an essential preventative measure for vulnerable residents at risk of pressure damage, and the absence of monthly audits meant there was no adequate system to confirm that mattresses were correctly set for residents' weight. The panel concluded that this failing was a departure from the standards expected of a registered nurse, placed Resident R at risk of serious harm and was sufficiently serious to amount to misconduct.

Charge 16

The panel considered its earlier findings in respect of the vulnerability of residents at the Home, including residents who were bedbound, at risk of falls, or had dysphagia and other care needs, and noted that call bells were essential to ensure that residents could promptly receive help.

The panel also noted evidence that if call bells were not answered promptly, residents could be left without assistance in circumstances which may have serious consequences.

The panel took into account evidence that there had been known concerns about call bell response times in the Home and that action had previously been ordered by the CCG. The panel considered that, where there was a known issue, it was necessary to take proactive steps and have appropriate systems or contingency plans in place.

The panel was of the view that Mrs Cooper had a responsibility as a registered nurses in her role as deputy manager and considered that the failure to ensure call bells were

answered promptly was a departure from the standards expected of a registered nurse and was sufficiently serious to amount to misconduct.

Charge 17 (17a, 17b, 17c)

The panel considered its previous findings of fact that Mrs Cooper had provided inaccurate information to the CQC, in circumstances where she was the most senior person present at the Home at the relevant time.

The panel noted that Mrs Cooper was in a position of responsibility as a registered nurse in her role as deputy manager of the Home, and was of the view that providing inaccurate representations to the CQC regarding fundamental aspects of nursing care was sufficiently serious to amount to misconduct.

Charge 18a

The panel considered its findings that Mrs Cooper was dishonest in representing information as accurate when she knew it was not, or may not be, accurate. The panel considered that this dishonesty in relation her communications with the CQC was serious, fell far below the standards expected of a registered nurse and therefore amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The panel finds that patients were put at risk of serious harm as a result of Mrs Cooper's misconduct. Mrs Cooper's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It considered that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that Mrs Cooper had demonstrated no meaningful insight into the regulatory concerns. It noted that Mrs Cooper's position was that she was not directly involved in the care of the residents, that the Registered Manager of the Home was responsible for care planning, and that the allegations held her accountable for the failures of others. The panel considered that this demonstrated a lack of understanding of her own responsibilities as a registered nurse in her role as deputy manager, the seriousness of the failings, and the impact on residents, colleagues, the Home and public confidence in the nursing profession and the NMC as a regulator.

The panel noted that Mrs Cooper had provided very limited information to the NMC. It acknowledged that whilst Mrs Cooper has stated that she has retired, this does not remove the need to assess current impairment. The panel considered that it has no evidence before it of remediation, relevant training, strengthened practice or remorse. It took into account that whilst it does have some testimonials before it, they are historic in nature and do not address the specific concerns in this case.

The panel was satisfied that whilst the misconduct in this case is capable of being remedied, it is not easily remediable as the concerns relate to a broad range of serious failings in care planning, monitoring, escalation, record keeping and management

responsibility over a prolonged period of time. The panel was also of the view that Mrs Cooper's misconduct in terms of dishonesty is very difficult to remediate.

The panel is therefore of the view that there is a real risk of repetition based on the absence of insight, remediation, strengthened practice or accountability from Mrs Cooper. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because the misconduct is serious, involved vulnerable residents, occurred whilst Mrs Cooper was a registered nurse in her role as deputy manager, and included dishonesty in her communication with the CQC. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Cooper's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Jones submitted that it is the NMC's position that the appropriate and proportionate sanction in respect of Mrs Cooper was a striking-off order.

Ms Jones informed the panel that she intends to rely upon the submissions she had made at the impairment stage and submitted that those matters are also relevant to the panel's consideration in respect of sanction. Ms Jones submitted that, having found Mrs Cooper's fitness to practise currently impaired, the panel should conclude that a striking-off order is the appropriate sanction.

Ms Jones submitted that a significant period of time has passed since the events giving rise to the charges. She submitted that this panel may consider whether this significant period of time has provided Mrs Cooper an opportunity to demonstrate that she has strengthened her practice and remediated. Ms Jones submitted that despite this, the panel's finding of current impairment demonstrates that sufficient remediation has not been achieved.

Ms Jones submitted that the panel should have regard to the principle of proportionality when considering sanction. She informed the panel that whilst the panel is required to balance the interests of the public against those of Mrs Cooper, greater weight should be given to the public interest, including the need to maintain public confidence in the

nursing profession and uphold proper professional standards, than to the personal consequences for Mrs Cooper of the sanction imposed.

Ms Jones submitted that the proved charges are serious and that there had been no meaningful insight, and at best, only limited insight, demonstrated by Mrs Cooper. She submitted that in these circumstances, a striking-off order is the most appropriate and proportionate sanction in respect of Mrs Cooper.

In relation to Mrs Cooper, Ms Jones submitted that there are a number of aggravating factors which the panel should take into account. She submitted that there had been widespread failings over a sustained period of time, giving rise to a significant risk of harm to residents, and there was also a significant period of time during which harm was neither identified nor acted upon.

Ms Jones submitted that for the reasons previously provided in her submissions, a striking-off order is most suitable and proportionate sanction in Mrs Cooper's case.

Ms Jones submitted that the matters found proved in this case are serious and raise fundamental questions regarding the professionalism of Mrs Cooper. She submitted that public confidence in the nursing profession would be undermined if Mrs Cooper was not struck off the register.

Ms Jones further submitted that there has been no adequate explanation or justification for Mrs Cooper's conduct and that, in the absence of any evidence explaining their behaviour or demonstrating meaningful remediation, there remained a real risk that Mrs Cooper would repeat similar conduct in the future.

Ms Jones invited the panel to conclude that a striking-off order in respect of Mrs Cooper was the necessary, appropriate and proportionate sanction.

Decision and reasons on sanction

Having found Mrs Cooper's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mrs Cooper's conduct placed highly vulnerable residents at risk of suffering harm.
- There was a pattern of misconduct relating to a wide range of clinical failings over a sustained period of time.
- Mrs Cooper occupied a senior position of responsibility within the Home
- The residents concerned were particularly vulnerable and dependent upon those responsible for their care.
- Actual harm was caused to residents, together with a significant ongoing risk of further harm.
- Mrs Cooper failed to respond appropriately, despite repeated concerns and opportunities for improvement identified by external bodies, including the CQC and CCG.
- Mrs Cooper demonstrated little meaningful insight into her misconduct and failed to accept responsibility.
- Mrs Cooper's reflective material sought to deflect blame rather than demonstrate genuine remorse or reflection.
- The panel also attached significant weight to Mrs Cooper's dishonesty, which it considered to be a serious aggravating feature and indicative of a serious attitudinal concern.

The panel was unable to identify any mitigating factors. It concluded that Mrs Cooper's reflective material did not demonstrate genuine insight or remediation. There was no evidence of apology, strengthened practice, training, meaningful reflection or acceptance of responsibility.

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 next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that Mrs Cooper's actions were at the higher end of the spectrum, and it found that there is a risk to patient and public safety. The panel attached significant weight to the vulnerability of the residents impacted, the actual harm caused, the continuing risk of harm, and Mrs Cooper's repeated failures to respond appropriately, despite intervention and support from external organisations including the CQC and CCG.

The panel further considered that Mrs Cooper's dishonesty significantly increases the seriousness of the case, demonstrates a serious attitudinal concern and undermines confidence in her integrity as a registered nurse, particularly in the circumstances in which it arose.

The panel therefore determined that a sanction that does not restrict Mrs Cooper's practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on Mrs Cooper's registration. In considering whether conditions of practice are appropriate, the

panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026).

The panel, having regard to the nature and seriousness of Mrs Cooper's conduct, was of the view that no relevant, proportionate, workable or measurable conditions could adequately address the concerns identified in this case, to protect patients and to uphold professional standards. It considered that this was not a case involving errors that could be remedied through supervision or retraining, as Mrs Cooper's misconduct concerned fundamental failures in basic nursing care in a leadership position, management, governance and professional accountability over an extended period of time.

The panel also noted that Mrs Cooper has not demonstrated any real willingness to engage with remediation, despite previous support and opportunities provided. The panel was therefore of the view that it is unlikely that Mrs Cooper would comply with or benefit from a conditions of practice order. The panel therefore determined that a conditions of practice order would not be appropriate in the circumstances.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *‘the charges found proved are at the most serious end of the spectrum and call into question the professional’s suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.’*

Given Mrs Cooper’s lack of engagement, limited insight, lack of remorse, together with no evidence of training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely. The panel also took into account that Mrs Cooper had continued to minimise her responsibility despite the seriousness of the failings and the harm caused.

The panel considered whether the risks identified could be managed by Mrs Cooper being temporarily removed from the Register, it considered that for reasons already given this would be unlikely. It therefore concluded that a temporary removal from the register, even if subject to review, would not be sufficient to protect the public, uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved.

The panel was of the view that Mrs Cooper’s dishonesty towards the CQC represented a serious breach of the standards expected of a registered nurse and further undermined public confidence.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction, and would not adequately protect the public, maintain public confidence in the profession or uphold proper professional standards.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel determined that Mrs Cooper's misconduct, when viewed alongside her dishonesty and continuing lack of insight, raised fundamental questions about her professionalism and was fundamentally incompatible with continued registration.

The panel was of the view that the findings in this particular case demonstrate that Mrs Cooper's actions were serious and to allow her to continue practising would put the public at serious risk of harm and would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mrs Cooper in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Jones, who made an application for an interim suspension order to be imposed for a period of 18 months, which will cover the intervening appeal period. Ms Jones submitted that an interim order is necessary for the protection of the public and is also in the public interest.

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

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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 on imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any appeal period.

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

That concludes this determination.