Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Friday 29 September 2023 – Friday 6 October 2023
Tuesday 10 October 2023 – Wednesday 25 October 2023
Friday 27 October 2023 – Wednesday 1 November 2023
Monday 19 February 2024 – 1 March 2024
Wednesday 17 April – Friday 19 April 2024

Virtual Hearing

Name of Registrant:	**Karen Dorothy Lea**
NMC PIN	75Y0952E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – December 1999 Registered Midwife – December 1999
Relevant Location:	Wirral
Type of case:	Misconduct
Panel members:	Pamela Johal (Chair, Lay member) Louise Poley (Registrant member) Louise Fox (Lay member)
Legal Assessor:	Charles Parsley (29 September 2023) Christopher McKay (2 October 2023 – 6 October 2023) & (10 October 2023 – 27 October 2023) & (22 February – 1 March 2024) & (17 – 19 April 2024) Sean Hammond (30 October – 1 November 2023) Paul Hester (19 February 2024 – 21 February 2024)
Hearings Coordinator:	Taymika Brandy (29 September 2023 – 4 October 2023) & (16 October 2023 – 20 October 2023) (30 October – 1 November 2023) & (19 February 2024 – 21 February 2024) & (26 February – 1 March 2024) & (17 – 19 April 2024)

	Sherica Dosunmu (5 – 6 October 2023) Rene Aktar (10 – 13 October 2023) Zahra Khan (23 – 25 & 27 October 2023) Ruth Bass (22 – 23 February 2024)
Nursing and Midwifery Council:	Represented by Dr Raj Joshi, Case Presenter (29 September 2023 – Wednesday 1 November 2023) Represented by Ben Edwards, Case Presenter (19 February 2024 – 1 March 2024) & (17 – 19 April 2024)
Ms Lea:	Not present and unrepresented at the hearing
Facts proved:	1.b.i., 1.c., 2.a.i., 2.a.ii., 2.a.iii., 2.a.iv., 2.a.v., 2.b.i, 2.c. (in its entirety), 2.d.iii., 2.e.i(partially proved), 2.f.i., 2.g.ii.(proved in its entirety), 2.g.iii., 2.i.(proved in its entirety), 3.a.ii., 3.c., 4.a. (proved in its entirety), 4.c., 5.a.i., 5.a.iii., 5.a.iv., 5.a.v., 5.b.ii., 5.c. (in its entirety), 5.d., 6.c., 7.b.iii., 7.b.iv., 7.c.i., 7.c.iii., 8.a.ii., 8.a.iii., 8.b.i., 8.c.i., 8.d., 9., 10.a. (in its entirety), 10.d.i.,10.d.iv.,10.d.vii.,10.d.xi.,10.e., 10.f.i.,10.f.ii.,10.f.iii., 10.h.ii.,10.h.iii.,10.h.iv., 10.i.iii,10.j., 11.a.i.,11.b.,12.a.(in its entirety), 12.b., 12.c.,13., 14.a.i-vi.,14.b.i., 15.a.i.,15.a.ii.,15.a.iv., 16.a.i.,16.a.ii.,16.a.v.,16.a.vi., 16.b., 16.c.i.,16.c.ii.,17., 18. (in its entirety),19.a.,19.b.,19.c.,19.d.ii., 20. (in its entirety), 21.a.,21.b.,23., 24., 25.a.,25.b.,26.a., 27.b., 28. and 29.
Facts not proved:	1.a. (in its entirety), 1.b.ii., 2.a.vi. (in its entirety), 2.b.ii., 2.b.iii.,2.d.i.,2.d.ii.,2.d.iv., 2.e.ii., 2.e.iii., 2.f.ii., 2.f.iii., 2.g.i., 2.h. (in its entirety), 3.a.i., 3.b., 4.b., 5.a.ii., 5.b.i., 6.a. (in its entirety), 6.b. (in its entirety), 7.a. (in its entirety), 7.b.i., 7.b.ii., 7.c.ii, 8.a.i., 8.c.ii., 10.b. (in its entirety), 10.c., 10.d.ii. (in its entirety), 10.d.iii., 10.d.v.,10.d.vi.,10.d.viii.,10.d.ix.,10.d.x.,10.f.iv.,10.g. (in its entirety), 10.h.i., 10.i.i.,10.i.ii., 11.a.ii., 11.c., 14.a.vii., 15.a.iii., 15.b., 16.a.iii.,16.a.iv.,16.c.iii.,16.d. (in its entirety), 19.d.i.,21.c., 22., 25.c.,25.d.,25.e.,26.b. and 27.a.
Fitness to practise:	**Impaired**

Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Lea was not in attendance and that the Notice of Hearing letter had been sent to Ms Lea's registered email address by secure email on 16 August 2023.

The Notice of Hearing was also sent to Ms Lea's representative at the Royal College of Nursing (RCN) on 16 August 2023.

Dr Joshi, 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 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 Ms Lea's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Lea 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 Ms Lea

The panel next considered whether it should proceed in the absence of Ms Lea. It had regard to Rule 21 and heard the submissions of Dr Joshi.

Dr Joshi referred the panel to a letter dated 26 September 2023 from Ms Lea's RCN representative. He explained that due to an administrative error, this letter was not received by Ms Lea's NMC case coordinator until late afternoon on 29 September 2023. The letter states:

'Our member will not be attending the hearing nor will they be represented. No disrespect is intended by their non-attendance. Our member has received the notice of hearing and is happy for the hearing to proceed in their absence. They are keen to continue to engage with the proceedings. We set out below our member's representations and ask that this letter be placed before the panel at the hearing.'

Dr Joshi invited the panel to continue in the absence of Ms Lea and submitted that Ms Lea had voluntarily absented herself.

The panel accepted the advice of the legal assessor which included reference to the relevant cases of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

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

The panel has decided to proceed in the absence of Ms Lea. In reaching this decision, the panel has considered the submissions of Dr Joshi, the representations from Ms Lea's RCN representative made on her behalf, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Lea's RCN representative has informed the NMC that they have received the Notice of Hearing and confirmed that they are content for the hearing to proceed in Ms Lea's absence;
- Ms Lea's RCN representative has provided written representations for the panel to consider;
- No application for an adjournment has been made by Ms Lea;
- There is no reason to suppose that adjourning would secure her attendance at some future date;

- Three witnesses are due to attend this hearing to give evidence;
- Not proceeding may inconvenience the witnesses and their employer;
- The charges relate to events that occurred in 2020 and 2021, and further delay may have an adverse effect on the ability of witnesses accurately to recall events.

There is some disadvantage to Ms Lea in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to Ms Lea and her RCN representative via secure email, they will not be able to challenge the evidence relied upon by the NMC at the hearing and will not be able to give evidence on her 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.

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

Decision and reasons on application to amend the charge

Before making its decision on the facts of this case, the panel, of its own volition, invited Dr Joshi to consider an amendment to charge 10. d. viii., to provide clarity to the charge and to properly reflect the evidence in this case.

Proposed amendment

'10. In respect of Service User M, failed to ensure that:
d. The patient's care plans were adequate, in that:
viii. ~~Dressing~~ **R**epositioning records were not completed every 2-3 hours as advised by the Tissue Viability team,'

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

Dr Joshi accepted that an amendment to charge 10. D. viii., would provide clarity charge and properly reflect the evidence in this case.

The panel was of the view that such an amendment, as applied for, was relevant, fair and provided clarity to the charge. The panel was satisfied that there would be no prejudice to Ms Lea and no injustice would be caused to either party by the agreed amendment being allowed. It therefore amended the charge of its own volition as proposed above.

Decision and reasons on further application to amend the charge

The panel heard an application made by Dr Joshi to amend the wording of charge 10.d. vii. The proposed amendment is as follows:

'10. In respect of Service User M, failed to ensure that:

d. The patient's care plans were adequate, in that:

vii. ~~Hypertension~~ **Hyperthyroidism** plans lacked clear and/or consistent monitoring information'

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

The panel was satisfied that there would be no prejudice to Ms Lea and no injustice would be caused to either party by the proposed amendment being allowed. It therefore granted the application to amend the charge as applied for above.

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

The panel, of its own volition, determined that parts of this hearing be held in private, due to [PRIVATE].

The legal assessor reminded the panel that while Rule 19(1) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules), 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, third party or by the public interest.

Dr Joshi did not object to this application.

Details of charge (as amended):

That you, a registered nurse, whilst working as the Registered Manager of Sandrock Nursing Home:

1. In respect of Service User A, failed to ensure that:

    a. Accurate records of medication administration were kept, in that:

        i. Between 9 and 25 April 2021, 2 Memantine 10mg tablets were prescribed every morning, but only 30 tablets were recorded as being administered when 34 should have been administered and recorded, **[NOT PROVED]**
        ii. The MAR chart, dated 26 April 2021, showed no signatures for the administration of Memantine 10mg, **[NOT PROVED]**
        iii. A second MAR chart for Memantine 20mg was started on 26 April 2021, but not signed until 27 April 2021, **[NOT PROVED]**
        iv. Between 8 and 27 April 2021, 2 different MAR charts were used in for Senna 7.5mg tablets, with different signatures on both charts, **[NOT PROVED]**

v. On 8 April 2021, a signature on a Senna 7.5mg MAR chart had been crossed out without note or explanation, **[NOT PROVED]**
vi. On 11 April 2021, a signature on a Senna 7.5mg MAR chart was missing without note or explanation, **[NOT PROVED]**
vii. 2 different MAR charts were used for Sinemet 12.5/50mg, MAR chart 1 covering 8 to 20 April 2021 and MAR chart 2 covering 15 to 26 April 2021, with both charts being signed on 16 to 20 April 2021, **[NOT PROVED]**

b. The patient's medicines were reconciled when they were discharged from hospital, the discharge summary stating that there were no changes to their preadmission medicines, in that:

i. Hyoscine, a prescribed medicine, was not included on the patient's MAR chart and/or a review of Hyoscine was not carried out, **[PROVED]**
ii. Omeprazole 20mg, listed on the discharge letter, was not included on the patient's MAR chart covering 26 and 27 April 2021, **[NOT PROVED]**

c. In May 2021, the patient had an up-to-date allergy status in their notes, **[PROVED]**

2. In respect of Service User B, failed to ensure that:

a. The patient's medication was administered safely, in that:

i. Between 26 April and 5 May 2021, Aspirin and Lansoprazole were administered together when Aspirin should be administered with or just after food and Lansoprazole should be administered 30-60 minutes before food, **[PROVED]**
ii. Between 6 and 16 December 2021, Aspirin and Lansoprazole were administered together when Aspirin should be administered with or

just after food and Lansoprazole should be administered 30-60 minutes before food, **[PROVED]**

iii. In May 2021, the patient was prescribed Lansoprazole 15mg, Mirtazapine 30mg, Nicorandil 10mg, Sertraline 100mg, Simvastatin 40mg, and Zopiclone 3.75mg tablets, when a January 2021 therapy report stated that the patient required a Level 4 pureed diet, requiring no solid tablets, **[PROVED]**

iv. In December 2021, the patient was prescribed Lansoprazole 15mg, Mirtazapine 30mg, Nicorandil 10mg, Sertraline 100mg, and now Carbocistein 375mg tablets, when a January 2021 therapy report stated that the patient required a Level 4 pureed diet, requiring no solid tablets, **[PROVED]**

v. An unlabelled Salamol Easi-breathe inhaler was used for the patient when they were prescribed a Ventolin Evohaler, **[PROVED]**

vi. On 24 November 2021, a Speech and Language Therapy ('SALT') assessment stated that the patient required a Level 2 pureed diet, which was not followed on 1 or more of the following occasions:

1. 20.11.21 at 14:44,
2. 21.11.21 at 11:51,
3. 25.11.21 at 20:50,
4. 27.11.21 at 17:44,
5. 28.11.21 at 14:43,
6. 30.11.21 at 18:10,
7. 09.12.21 at 12:57,

[NOT PROVED IN ITS ENTIRETY]

b. Accurate records of medication administration were kept, in that:

i. Between 8 November and 20 December 2021, the patient was administered 70 doses of Trimblow inhaler, when their MAR chart recorded the administration of 168 doses, **[PROVED]**

ii. On 13 December 2021, at 9:30am, a PRN Salbutamol nebule was administered, and at 10:00am, a PRN Ventolin Evohaler dose was

administered, with no rationale recorded for the administration of both PRN medicines in half an hour, **[NOT PROVED]**

iii. On 13, 14, and/or 16 December 2021, PRN Ventolin Evohaler was administered without a record of medical advice sought for the administration of the medicine, **[NOT PROVED]**

c. PRN protocols were adequate, in that:

i. The patient was prescribed a Ventolin Evohaler, when the PRN protocol did not include information on how to assess the need for the inhaler, and/or its maximum dose, and/or its use alongside other PRN medicine, **[PROVED]**

ii. The patient was prescribed Salbutamol Nebules and there was no PRN protocol in place for this medicine, **[PROVED]**

d. Patient records were adequate, in that:

i. The patient's type of dementia and/or how it affected their health was not recorded, **[NOT PROVED]**

ii. On 8 January 2021, the patient was diagnosed with Dysphagia, but records lacked information on patient support, **[NOT PROVED]**

iii. Contradictory SALT assessments were included in the care plan, **[PROVED]**

iv. The COVID-19 risk assessment was not specific to the patient, **[NOT PROVED]**

e. Capacity assessments were adequate, in that:

i. Capacity assessments carried on 7 July and 10 December 2021 did not identify specific issues for which capacity had been assessed, **[PARTIALLY PROVED]**

ii. On 7 July 2021, a capacity assessment and bed rail capacity assessment were conducted, when they should not have been carried out on the same day, **[NOT PROVED]**

iii. The consent plan did not include the patients consent and/or included conflicting information relating to their capacity, **[NOT PROVED]**

f. The Personal Emergency Evacuation Plan ('PEEP') was adequate, in that it:

i. Was not dated, **[PROVED]**

ii. Contradicted other capacity records, **[NOT PROVED]**

iii. Made no reference to Deprivation of Liberty safeguards, **[NOT PROVED]**

g. The Nutrition Care Plan was adequate, in that:

i. It stated the patient required fluids of 1,200-1,500mls per day, and 1,500-2,000mls per day, **[NOT PROVED]**

ii. The patient's weight was to be recorded monthly, but was not recorded on 1 or more of the following months:

1. November 2020,
2. December 2020,
3. January 2021,
4. March 2021,
5. April 2021,
6. June 2021,
7. August 2021,

[PROVED IN ITS ENTIRETY]

iii. In February 2021, the patient's weight was recorded at 71.2kgs, and in November 2021 at 63.3kgs, but no explanation was given for the 7.9kgs weight loss, **[PROVED]**

h. Daily records were adequate, in that:

i. Between 1 November and 16 December 2021, Vital Statistic Records for fluid intake did not always include the specific amount of fluid consumed, **[NOT PROVED]**
ii. On 1 December 2021, the quantity of food served and/or eaten was not recorded, **[NOT PROVED]**
iii. On 2 December 2021, at lunchtime, the quantity of food served and/or eaten was not recorded, **[NOT PROVED]**

i. Temperature check records were adequate, in that:

i. They did not consider COVID-19,
ii. The only checks covering January and February 2021 took place on 27 and 28 February 2021,

[PROVED IN ITS ENTIRETY]

3. In respect of Service User D, failed to ensure that:

a. Latanoprost eye drops were administered appropriately, in that,

i. On 7, 21, and 23 April 2021, the patient's topical daily chart was not signed to show the eye drops had been administered, **[NOT PROVED]**
ii. The eye drops were stored in a stock cupboard prior to opening, when they need to be stored at 2-8°C, **[PROVED]**

b. Co-codamol 15/500mg were given regularly or a PRN protocol for its administration was put in place, **[NOT PROVED]**

c. In May 2021, the patient had an up-to-date allergy status in their notes, **[PROVED]**

4. In respect of Service User F, failed to ensure that:

    a. Accurate records of medication were kept, in that:

        i. The medication profile showed that no Paracetamol 500mg had been sent, received, or brought forward, when 86 tablets were dispensed on 15 December 2020 and/or 32 tablets were dispensed on 20 August 2020,
        ii. The medication profile showed that no Co-codamol 30/500mg had been sent, received, or brought forward, when 88 tablets were dispensed on 3 October 2020,
        iii. The medication profile showed that no PEPTAC liquid had been sent, received, or brought forward, when it had been dispensed on 27 November 2020,
        iv. The medication profile showed that no Cosmocol sachets had been sent, received, or brought forward, when 28 sachets had been dispensed on 24 December 2020,
        v. The medication profile showed that no Glucose 40% oral gel had been sent, received, or brought forward, when 3 25g tubes were in stock on 5 May 2021,
        vi. On 2 September 2020, the medicines record chart for Co-drydramol 10/500mg showed 98 tablets in stock, leaving 45 tablets unaccounted for,
        vii. On 5 May 2021, the medicines record chart for Co-drydramol 10/500mg showed 98 tablets in stock, when 100 tablets were in stock,

        [PROVED IN ITS ENTIRETY]

    b. The patient was administered prescribed doses of Furosemide 40mg or said medication was signed for as administered on the patient's MAR on 10 and/or 11 December 2021, **[NOT PROVED]**

c. In May 2021 and/or December 2021, the patient had an up-to-date allergy status in their notes, **[PROVED]**

5. In respect of Service User G, failed to ensure that:

    a. Accurate records of medication were kept, in that:

        i. The medication profile showed that no Co-codamol 8/500mg had been sent, received, or brought forward, when 93 tablets were dispensed on 27 November 2020 and/or 100 tablets were dispensed on 24 December 2020, **[PROVED]**
        ii. The medication profile showed that no Co-codamol 15/500mg had been sent, received, or brought forward, when 72 tablets were dispensed on 11 May 2020, **[NOT PROVED]**
        iii. The medication profile showed that no Macrogol sachets had been sent, received, or brought forward, when 2 sachets were in stock on 5 May 2021, **[PROVED]**
        iv. No Enzalutamide 40mg was recorded as being in stock, when 2 labelled boxes and/or 1 unlabelled box were dispensed on 8 April 2021, **[PROVED]**
        v. 5 Midazolam 5mg/ml injections were received on 29 September 2021, In December 2021 only 3 were in stock, but none were recorded as administered to the patient, **[PROVED]**

    b. The patient's medication was administered safely, in that:

        i. On 2 May 2021, Alendronic Acid and Dexamethasone were administered together when Alendronic Acid should be administered 30 minutes before food, drink, and any other medication, and Dexamethasone should be administered with or after food, **[NOT PROVED]**
        ii. A Midazolam 5mg/ml injection prescribed to Service User G was administered to Service User T, **[PROVED]**

c. PRN protocols were adequate, in that:

    i. The patient was prescribed Metoclopramide 10mg, but there was no PRN protocol in place, **[PROVED]**
    ii. The patient was prescribed Co-codamol 8/500mg, but there was no PRN protocol in place, **[PROVED]**

d. In May 2021, the patient had an up-to-date allergy status in their notes, **[PROVED]**

6. In respect of Service User H, failed to ensure that:

    a. Accurate records of medication administration were kept, in that, on 29 April 2021:

        i. No lunchtime dose of Docusate 100mg was administered or signed for, **[NOT PROVED]**
        ii. No lunchtime and/or teatime dose Co-codamol 8/500mg was administered or signed for, **[NOT PROVED]**
        iii. No explanation was recorded for the omissions at charges 6.b.i and/or 6.b.ii, **[NOT PROVED]**

    b. A PRN protocol was in place for Lorazepam 1mg, **[PROVED]**

    c. In May 2021, the patient had an up-to-date allergy status in their notes, **[PROVED]**

7. In respect of Service User I, failed to ensure that:

    a. Accurate records of medication administration were kept, in that:

i. In April 2021, different symbols were used on the patient's MAR chart for olive oil ear drops without explanation, **[NOT PROVED]**
ii. On 5 May 2021, olive oil ear drops were not administered or not recorded as administered on the patient's MAR chart, **[NOT PROVED]**
iii. Between 26 April and 4 May 2021, Senna 7.5mg was administered PRN, 2 tablets on 26 April 2021, 1 tablet every other day, with no rationale recorded as to why different doses were required, **[NOT PROVED]**

b. The patient's medication was administered safely, in that:

i. In April 2021, olive oil ear drops were not administered twice daily, **[NOT PROVED]**
ii. Olive oil ear drops, dispensed on 11 February 2021, were used after 28 days of opening, **[NOT PROVED]**
iii. On 3 May 2021, Alendronic Acid was administered together with other medicines when it should be administered 30 minutes before food, drink, and other medication, **[PROVED]**
iv. Between 26 April and 4 May 2021, Mebeverine was administered at teatime, when it should be administered 20 minutes before food, **[PROVED]**

c. PRN protocols were adequate, in that:

i. The patient was prescribed Senna 7.5mg, but there was no PRN protocol in place, **[PROVED]**
ii. The patient was prescribed Cosmocol sachets, up to 3 doses per day, but there was no information in the PRN protocol on how to assess the appropriate dose, **[NOT PROVED]**
iii. The patient was prescribed Paracetamol 500mg, 2 tablets up to 4 times daily, and Codeine 15mg, 1 or 2 tablets up to 4 times daily, but there was no information in the PRN protocol on how to assess

which medication should be used first and/or how to assess the correct dose of Codeine, **[PROVED]**

8. In respect of Service User J, failed to ensure that:

    a. Accurate records of medication administration were kept, in that:

        i. The medication profile showed that no Lantus Solostar 100unit/ml insulin pens were in stock, when 6 were in the fridge labelled for the patient, **[NOT PROVED]**
        ii. The medication profile showed that a Contour XT blood sugar testing machine and/or testing strips were not in stock when they were, **[PROVED]**
        iii. Fridge temperatures were not recorded daily, **[PROVED]**

    b. The patient's medication was administered safely, in that:

        i. A Nexus GlucoRx blood sugar testing machine was used when the test strips and/or the solution to calibrate the machine was out of date, **[PROVED]**

    c. Medication was stored safely, in that:

        i. The fridge temperature fell to -24°C, when the minimum appropriate temperature was 0°C, **[PROVED]**
        ii. Lantus Solostar 100unit/ml insulin pens were kept in the fridge, when they should be stored between 2 and 8°C, **[NOT PROVED]**

    d. The PRN protocol for Glucogel had information as to how the need for the medicine would be assessed, **[PROVED]**

9. In respect of Service User K, failed to ensure the patient's Nexus blood sugar testing strips were in date, **[PROVED]**

10. In respect of Service User M, failed to ensure that:

a. Accurate records of medication administration were kept, in that:

i. On 6 December 2021, the medication profile showed that there was no Tranexamic acid 500mg tablets in stock when at least 54 tablets were in stock, **[PROVED]**
ii. Between 4 February and 19 July 2020, approximately 27 Paracetamol 500mg tablets went unaccounted for, **[PROVED]**
iii. Between 19 July 2020 and 20 October 2021, approximately 100 Paracetamol 500mg tablets went unaccounted for, **[PROVED]**
iv. On 6 December 2021, the medication profile showed that no Paracetamol 500mg tablets had been received or brought forward, when there were 92 tablets in stock, **[PROVED]**
v. Between 30 October and 11 November 2021, 4 Amoxycillin 500mg capsules went unaccounted for, **[PROVED]**

b. The patient's medication was administered safely, in that:

i. On 13 December 2021, Alendronic acid, Levothyroxine, and other medicines, were administered together, when Alendronic acid should be administered 30 minutes before food, drink, and other medication, **NOT PROVED]**
ii. Between 6 and 16 December 2021, Levothyroxine was administered with other medication when it should be administered 30-60 minutes before food, drink, and other medication, **[NOT PROVED]**
iii. On 29 October 2021, 1 capsule Amoxycillin 500mg was given at breakfast, lunch, and/or dinner when 2 capsules were prescribed, **[NOT PROVED]**

iv. On 16 November 2021, a double dose of Ciprofloxacin 500mg was administered, a 1 Ciprofloxacin 500mg tablet went unaccounted for, **[NOT PROVED]**

c. On 6 December 2021, the patient had Senna 7.5mg as prescribed, **[NOT PROVED]**

d. The patient's care plans were adequate, in that:

i. The Consent Care Plan did not include a patient specific statement and/or capacity assessment, **[PROVED]**
ii. Patient notes included contradictory statements regarding consent, in that:
    1. The Mood and Behaviour care plan suggested the patient had fluctuating capacity,
    2. The 7 April 2020 DNAR, Independent Mental Capacity Advocate report 2 September 2021 and Mental Capacity Assessment 17 September 2021 determined no capacity,
    3. Staff informed the Tissue Viability team that the patient had capacity to understand the risks of not complying with wound care,

    [NOT PROVED IN ITS ENTIRETY]
iii. No specific mental health and/or dementia care plan was put in place, **[NOT PROVED]**
iv. No assessment had taken place for the patient's capacity in respect of a wheelchair safety belt, **[PROVED]**
v. No individual plan was put in place for Multiple Sclerosis, **[NOT PROVED]**
vi. No patient specific details were included in patient plans relating to diabetes, **[NOT PROVED]**
vii. Hyperthyroidism plans lacked clear and/or consistent monitoring information, **[PROVED]**

viii. Repositioning records were not completed every 2-3 hours as advised by the Tissue Viability team, **[NOT PROVED]**
ix. On 1 and/or 2 December 2021, food and fluid intake records omitted the quantities consumed, **[NOT PROVED]**
x. On 11 December 2021, accident and incident records failed to record how the patient was lifted, and/or whether the patient refused to wear their safety belt, **[NOT PROVED]**
xi. The COVID-19 risk assessment lack personal details, **[PROVED]**

e. On 11 December 2021, the patient's wheelchair assessment on the need for a safety belt was followed, **[PROVED]**

f. The patient's diabetes was adequately monitored, in that:

i. The patient's MAR chart showed no use of GluxoRx Nexus glucose testing stripsin October, November, and December 2021, **[PROVED]**
ii. Between 1 November and 16 December 2021, there was no record of blood glucose testing in the patient's daily records, **[PROVED]**
iii. There was no record of HbAC1 testing, **[PROVED]**
iv. There was no record of the patient attending the diabetic foot clinic, **[NOT PROVED]**

g. Weight recordings were adequate, in that:

i. On 2 February 2021, the patient was measured as weighing 68.5kgs,
ii. On 5 February 2021, the patient was measured as weighing 92.7kgs,
iii. On 23 February 2021, the patient was measured as weighing 92.7kgs,
iv. No explanation was given for the changes in weight, **[NOT PROVED IN ITS ENTIRETY]**

h. Skin Care plans were adequate, in that:

    i. The patient's Braden Scale Risk Assessment, dated 8 December 2021, and/or Pressure Sore Risk Assessment, dated 9 December 2021, failed to consider the patient's existing sores, **[NOT PROVED]**
    ii. The Skin Care Plan included contradictory information regarding the number of wounds, **[PROVED]**
    iii. Staff failed to follow the Tissue Viability team's advice following assessments on 25 August 2020 and/or 5 February 2021, **[PROVED]**
    iv. On 24 and 26 November, and 2 December 2021, wound assessments failed to include accurate information on wound size and/or include photographs of wounds, **[PROVED]**

i. Dressings were adequately changed, in that:

    i. On 5 December 2021, a dressing was changed a day late, **[NOT PROVED]**
    ii. On 9 December 2021, a dressing was changed 2 days late, **[NOT PROVED]**
    iii. Records failed to clearly identify which dressings had been changed. **[PROVED]**

j. In December 2021, the patient had an up-to-date allergy status in their notes, **[PROVED]**

11. In respect of Service User N, failed to ensure that:

    a. Medicine was appropriately administered, in that:

i. There were no records to show Daktacort had been applied, **[PROVED]**
ii. Records showed that Mediderma was only applied on 5 of 10 nights when it was required more frequently, **[NOT PROVED]**

b. Hypromellose eye drops, prescribed in October 2021, were in stock, **[PROVED]**

c. In December 2021, the patient had an up-to-date allergy status in their notes, **[NOT PROVED]**

12. In respect of Service User P, failed to ensure that:

a. Accurate records of medication were kept, in that:

i. Between 23 November and 7 December 2021, Nystan oral suspension was recorded on the patient's MAR chart with "o" without explanation, **[PROVED]**
ii. Between 23 November and 7 December 2021, on one or more occasion, administered Nystan oral suspension 51mls when only 30mls were available, **[PROVED]**

b. Medication was properly disposed of, in that:

i. 1 or more tubes of Biotene gel and/or a Hydroxocobalamin injection were left on a work surface, **[PROVED]**

c. In May 2021 and/or December 2021, the patient had an up-to-date allergy status in their notes, **[PROVED]**

13. In respect of Service User Q, failed to ensure that, Cosmocol sachets, dispensed on 29 September 2021, were properly disposed of, **[PROVED]**

14. In respect of Service User R, failed to ensure that:

a. Accurate records of medication were kept, in that:

i. On 8 November 2021 and/or 6 December 2021, the medication profile for a DuoResp inhaler showed that no inhalers had been sent, received, or brought forward, when 1 was dispensed on 29 September 2021, and on 16 December 2021, had doses remaining, **[PROVED]**

ii. Between 11 November and 15 December 2021, the MAR chart for the DuoResp recorded 133 doses as administered when the medication profile showed only 1 inhaler, containing 60 doses, in stock, **[PROVED]**

iii. No date of opening was recorded for the DuoResp inhaler, **[PROVED]**

iv. On 8 November 2021 and/or 6 December 2021, the medication profile for Cosmocol sachets showed that no sachets had been sent, received, or brought forward, when a box of 30 was dispensed on 29 September 2021, and on 16 December 2021, sachets were remaining, **[PROVED]**

v. Between 11 November and 15 December 2021, the MAR chart for the Cosmocol sachets recorded 50 doses as administered when the medication profile showed only 30 sachets in stock, **[PROVED]**

vi. On 11 October 2021, the medication profile for Epimax cream showed that 500mg had been received; none was sent, received, or brought forward on 8 8 November 2021 and/or 6 December 2021, and there was no record of the Epimax cream being applied, **[PROVED]**

vii. The MAR chart for Zapain 30/500mg did not show the time the medicine was administered, **[NOT PROVED]**

b. The patient's medication was administered safely, in that:

i. Between 6 and 16 December 2021, Lansoprazole 30mg and Mebeverine 135mcg were administered without regard to manufacturer's directions, **[PROVED]**

15. In respect of Service User S, failed to ensure that:

a. Accurate records of medication were kept, in that:

i. On 10 November 2021, the medication profile for Warfarin 1mg showed 82 tablets remaining when administration records suggested that 96 should have been remaining, **[PROVED]**
ii. On 29 November 2021, the medication profile for Warfarin 1mg showed 92 tablets remaining when administration records suggested that 78 should have been remaining, **[PROVED]**
iii. On 5 December 2021, administration records suggested that neither Warfarin 1mg nor 3mg had been administered, **[NOT PROVED]**
iv. On 6 December 2021, the medication profile for Warfarin 1mg and/or Warfarin 3mg showed 28 tablets in stock, failing to show the quantity brought forward, **[PROVED]**

b. The PRN protocol for Zapain included guidance as to the intervals between doses, **[NOT PROVED]**

16. In respect of Service User T, failed to ensure that:

a. Medication was given as prescribed, in that:

i. Between 1 October and 30 November 2021, Bioxtra gel and/or Viscotears were not administered as prescribed, **[PROVED]**
ii. On 29 November 2021, include Bioxtra gel and/or Viscotears were out of stock, **[PROVED]**

iii. On 6 December 2021, the patient's MAR chart did not include Bioxtra gel and/or Viscotears, **[NOT PROVED]**
iv. Between 15 and 18 December 2021, medicine was omitted from the patient's 24-hour syringe driver, **[NOT PROVED]**
v. On 15 December 2021, Hyoscine was out of stock, **[PROVED]**
vi. On 15 December 2021, the patient did not receive medication for at least 1 hour, **[PROVED]**

b. PRN protocols were put in place for medicines contained in the patient's hospital discharge letter of 30 November 2021, **[PROVED]**

c. Accurate records of medication were kept, in that:

i. Between 1 October and 8 October 2021, Morphine Sulphate 10mg/ml went unaccounted for, **[PROVED]**
ii. The controlled drugs register did not show times of administration, **[PROVED]**
iii. The syringe driver was not labelled to show the time the driving started, **[NOT PROVED]**

d. Care plans were adequate, in that:

i. The consent plan included contradictory evidence relating to the patient's capacity,
ii. The COVID-19 risk assessment was not specific to the patient, **[NOT PROVED IN ITS ENTIRETY]**

17. In respect of Service User U, in December 2021, failed to ensure that they had an up-to-date allergy status in their notes, **[PROVED]**

18. In respect of Service User V, failed to ensure that:

a. Between 14 and 21 December 2021, the patient received their prescribed Sertraline 50mg,

b. In December 2021, the patient had an up-to-date allergy status in their notes,
[PROVED IN ITS ENTIRETY]

19. In respect of Service User W, failed to ensure that:

a. The patient was not deprived of their personal possessions, **[PROVED]**

b. An investigation took place following the patient's discharge from hospital on 5 January 2021, **[PROVED]**

c. Sufficient temperature checks were taken, in that, between 1 April and 16 December 2021, temperature checks were only taken on 6 occasions, **[PROVED]**

d. Care plans were adequate, in that:

i. The consent plan included contradictory evidence relating to the patient's capacity, **[NOT PROVED]**
ii. The COVID-19 risk assessment was not specific to the patient, **[PROVED]**

20. Failed to ensure that one or more of the following medicines were stored with dispensing labels:

a. Lantus Solostar insulin pens,
b. Oral chemotherapy pack,
c. Daktacort,
d. Daktarin,
e. Olive oil ear drops,

[PROVED IN ITS ENTIRETY]

21. Failed to ensure that medication was stored appropriately, in that:

    a. The medicine fridge was unclean, **[PROVED]**
    b. There was no key for the medicine fridge, **[PROVED]**
    c. Waste medicine was not kept in locked cupboards, **[NOT PROVED]**

22. In May 2021, failed to ensure sufficient Paracetamol was in stock, **[NOT PROVED]**

23. Failed to adhere to government guidelines on COVID 19, in that:

    a. A staff testing spreadsheet was not set up until July 2021,
    b. Staff had gaps on the testing spreadsheet,
    c. Staff had not completed weekly PCR tests,
    d. Staff had not competed weekly LFT tests,

    [PROVED IN ITS ENTIRETY]

24. Failed to ensure all patient bedrooms were deep cleaned, **[PROVED]**

25. Failed to maintain proper staff training standards, in that not all staff:

    a. Completed their training, **[PROVED]**
    b. Were included on the staff training matrix, **[PROVED]**
    c. Received appraisals, **[NOT PROVED]**
    d. Were assessed on skills and/or competencies, **[NOT PROVED]**
    e. Received inductions and/or supervision, **[NOT PROVED]**

26. Failed to maintain proper levels of staffing, in that:

    a. No dependency tool and/or staffing level policy was in place for Sandrock Nursing Home, **[PROVED]**

b. Between 15 November and 6 December 2021, staffing numbers were inconsistent when the same staffing level was required, **[NOT PROVED]**

27. Failed to maintain adequate recruitment processes, in that:

    a. Insufficient effort was made to obtain references for 1 or more staff members, **[NOT PROVED]**
    b. References were not investigated, **[PROVED]**

28. On 16 December 2021, signed Service User T's record administration sheet to say that you had witnessed the administration of the patient's medication, when the medication had not yet been administered, **[PROVED]**

29. Your conduct at charge 28 was dishonest, in that you intended for anyone reading Service User T's record administration sheet to believe you had witnessed the administration of their medication when you had not, **[PROVED]**

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

Background

Ms Lea was referred to the NMC on 1 February 2022 by Witness 2, an Adult Social Care Inspector at the Care Quality Commission ('CQC'). At the time the concerns arose, Ms Lea was working as a registered nurse at Sandrock Nursing Home ("the Home"). Ms Lea started working at the Home in 2002 and became the Registered Manager in 2011. On 1 October 2010, Prasur Investments Limited was registered as the provider in respect of the Home.

The Home was first rated inadequate by CQC in 2017 due to significant breaches of multiple regulations. Some improvements were made during 2017, and a follow up inspection rated the Home as '*requires improvement'*. The improvements were not sustained, and it was again rated '*inadequate'* following an inspection in April 2018. A

follow up inspection in July 2018 found that some improvements had been made and in 2019, the Home was deemed compliant with the relevant regulations and was rated '*good'* overall.

In April 2021, an Infection Prevention and Control inspection commenced at the Home. The purpose of this was to check that action had been taken to mitigate risks associated with the COVID-19 pandemic. Serious concerns were identified regarding infection control and the management of infection control matters at the Home. As a result of concerns, the inspection was widened to consider the following domains:

- Is the service safe?
- Is the service effective?
- Is the service well led?

The Home was rated '*inadequate'* in all three domains inspected.

Witness 2 was the Lead Inspector at the material time, assisted by Witness 1, Pharmacist Medicines Inspector at the CQC. Both witnesses produced a CQC witness statement for CQC proceedings. These set out that multiple breaches of the relevant regulations were identified.

The CQC determined that the breaches presented a risk to the health, safety, and wellbeing of service users. Two Notice of Proposals ('NOP') were issued. One to remove the registration of the provider for all registered regulated activities and one to remove Ms Lea's registration as Registered Manager.

Ms Lea appealed the decision to cancel her registration. The provider's appeal was successful and the NMC was informed that the Home was permitted to continue with CQC registration subject to conditions, which included Ms Lea applying to de-register as the Home's Registered Manager. Ms Lea's application to de-register was accepted on 13 October 2022.

A further inspection took place at the Home on 16 and 20 December 2021 and 8 and 10 January 2022. The purpose of this inspection was to determine whether sufficient improvements had been made and to provide an update on the CQC's regulatory position. Witness 2 was again the Lead Inspector for the subsequent inspection, supported by Witness 1.

The inspection found that no significant improvements had been made and that in some areas such as medicines management, identified by Witness 1, the safety of the Home had declined further. Witness 2 found that the Home remained in breach of the regulations identified during the previous inspection. The Home was again rated inadequate in the three domains inspected.

The April 2021 inspection found that systems in place for assessing people's needs and risks were not effective, and that care or treatment was not always safe or appropriate. Where risks were identified, they were not always properly described, or plans were not in place to inform staff how to manage these.

The NMC identified the following regulatory concerns in relation to Ms Lea:

Poor management of a care home including:

- medication management
- assessing resident needs
- care planning
- risk management
- delivery of personal care
- wound management
- nutrition and hydration
- end of life care
- recruitment of staff
- staff support and training
- record keeping.

Decision and reasons on service of Notice of Hearing (heard on 29 February 2024)

At the outset of the resuming hearing, Mr Edwards on behalf of the NMC, informed the panel that Ms Lea was not in attendance. Further, that the Notice of Hearing letter for the resuming hearing had been sent to Ms Lea's registered email by secure email on 8 January 2024. The Notice of Hearing letter for the resuming hearing had also been sent to Ms Lea's RCN representative on 8 January 2024.

Mr Edwards submitted that it had complied with the requirements of Rules 11 and 32 (2) 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 time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Lea's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Lea has been served with the Notice of Hearing for the resuming hearing in accordance with the requirements of Rules 11 and 32 (2).

Decision and reasons on proceeding in the absence of Ms Lea

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

Mr Edwards submitted that Ms Lea has not been in contact with the NMC since the last sitting of this hearing and she was not in attendance at the previous sitting of this hearing. He submitted that it is in the public interest for an expeditious disposal of this case. Further, he submitted that this case has been ongoing for a considerable amount

of time and that it is in the interest of Ms Lea and the NMC that this case proceeds without further delay.

For these reasons, Mr Edwards invited the panel to exercise its discretionary power and to proceed in the absence of Ms Lea, as she had voluntarily absented herself.

The panel accepted the advice of the legal assessor which included reference to Rule 21 and Rule 32.

The panel has decided to proceed in the absence of Ms Lea. In reaching this decision, the panel has considered the submissions of Mr Edwards and the advice of the legal assessor. It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Lea's RCN representative had previously informed the NMC in a letter dated 29 September 2023, that they are content for the hearing to proceed in Ms Lea's absence;
- No application for an adjournment has been made by Ms Lea;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- It is in the interest of Ms Lea and the NMC that this case proceeds without further delay; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Lea.

Decision and reasons on facts

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, which included reminding the panel of the test for determining dishonesty as set out in the case of *Ivey v Genting Casinos* [UK] Ltd [2017] UKSC 67.

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 Dr Joshi on behalf of the NMC. The panel also took into account a bundle entitled '*KL submissions and enclosures'* provided by Ms Lea's representative, noting that within these representations there is limited information in regard to the specific charges from Ms Lea.

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 oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Pharmacist Medicines Inspector at the CQC; at the time of the allegations.
- Witness 2: Adult Social Care Inspector at the CQC; at the time of the allegations.
- Witness 3: Inspection Manager at the CQC; at the time of the allegations.

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 both the NMC and Ms Lea.

In most of the charges the NMC alleges that the registrant failed to ensure that certain duties were properly carried out in the Home. The panel noted that a number of the

charges relate to actions completed by staff that Ms Lea supervised. Before these charges can be found proved the panel needs to be satisfied that as a Registered Nurse and Registered Manager, she was under a duty to ensure that whatever actions are referred to in the charge were carried out appropriately.

The panel accepted the evidence of Witnesses 1 and 2 in relation to Ms Lea's responsibilities as the registered home manager to provide a safe and effective and well led service. Although Ms Lea was not always the nurse or member of staff directly responsible for the alleged incidents, for the facts found proved unless stated otherwise the panel found that Ms Lea as the Registered manager had overall responsibility to ensure that effective systems were in place to ensure that medication was administered safely, medication administration was recorded accurately, medication was stored safely, prescribed medication was in stock, PRN protocols were in place, care plans were adequate, recruitment processes were followed, that staff were appraised and supervised, allergies statuses were up to date, and that COVID-19 processes and procedures were followed.

The panel had regard to the written submissions made by the RCN on Ms Lea's behalf on 26 September 2023 in relation to the facts.

> *'We set out below our member's representations and ask that this letter be placed before the panel at the hearing.*
>
> *In relation to the charges the registrant is not providing a substantive response and reserving her position leaving the decision on these matters to the panel, we have attached the registrant's response to the case examiners to assist the panel in their decision making. […]*
>
> *During her time as Home Manager the registrant understands that the CQC determined that breaches of regulations had occurred and the Home was deemed inadequate and placed in special measures. The registrant has provided the attached reflection detailing her regret and remorse. The registrant understands that she was in a position of responsibility to ensure the safe and*

effective running of the Home. The registrant, as manager, would not have been in a position to be regularly completing individual care records or delivering care. She would also not be able to complete daily audits of all care records. The registered nurses employed will have individual repsobnislity [sic] for their daily duties.[…]

The registrant was not in a position to be completing individual care records, delivering personal care, wound management due to her role overseeing the Home. The Home was far too large for her to be undertaking the daily clinical activities of the staff nurses. We wish to remind the case examiners that individual registered nurses will be responsible for their own actions and should all be aware of the need to keep accurate records upon qualifying as a nurse. Home managers will also be bound by the decisions, resources, budget and culture of the company for which they are operating under. As has been referred to in the statement of Witness CC, the company was also considered responsible and we ask the Case Examiners to consider the company are the registrant's direct employers.'

As Ms Lea has not made a substantive response to most of the charges it should be taken as read that the panel has in borne these submissions in mind when considering each individual charge below.

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

Charge 1. a. i.

1. In respect of Service User A, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        i. Between 9 and 25 April 2021, 2 Memantine 10mg tablets were prescribed every morning, but only 30 tablets were recorded as being administered when 34 should have been administered and recorded.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Service User A's ('SUA') MAR (Medication administration record) chart dated from 8 April 2021.

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

> *'I examined a MAR for SUA which was dated 8 April 2021, the day of their admission to the service. The MAR showed they were prescribed Memantine 10mg; two to be taken every morning […] The records showed that 30 tablets were received, and nurses signed that two tablets were given each morning from 9 to 25 April 2021. This means a total of 34 tablets were signed as given, which is more than had been recorded as received […] evidencing the inaccuracies of the records.'*

The panel also had regard to SUA's MAR chart dated from 8 April to 25 April 2021 and considered that this supported Witness 1's CQC witness statement, in that 2 tablets were signed as administered from 9 to 25 April 2021. The panel noted that Witness 1's statement on 30 March 2022 was consistent with her oral evidence which the panel found credible.

However, although the panel found that there were errors in the recording of medication administration between 9 and 25 April 2021, it considered that Ms Lea could not be expected to have that level of oversight over such a short period of time. The panel concluded that the registered nurses at the Home were responsible for their own clinical practice and it was reasonable for Ms Lea to expect them to accurately record medication administration without the need for daily monitoring.

Accordingly, the panel determined that this charge is found not proved.

Charge 1. a. ii. & Charge 1. a. iii.

1. In respect of Service User A, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        ii. The MAR chart, dated 26 April 2021, showed no signatures for the administration of Memantine 10mg,
        iii. A second MAR chart for Memantine 20mg was started on 26 April 2021, but not signed until 27 April 2021.

These charges are found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUA's MAR charts, dated from 8 April 2021, 26 April 2021 and further chart dated from 27 April 2021.

The panel first took into account Witness 1's CQC witness statement:

> *'I examined the MARS for the 26 April 2021, and I saw there were no signatures for Memantine 10mg tablets; but there was an annotation which stated, "see new MAR Sheet with 20mg tablets instead of 10mg". I found another MAR dated 26 April 2021 which listed Memantine 20mg tablets, but they had not been signed as given on 26 April 2021 and instead an unexplained symbol"/" was used. I saw the new MAR commenced on 27 April 2021 and one tablet was signed as given at 8am on 27 April 2021. The evidence above shows that records were unclear and could not show that Memantine had been administered to SUA as prescribed.'*

The panel had regard to SUA's MAR chart dated from 8 April 2021 which confirmed Witness 1's findings above. The panel also noted that on SUA's MAR chart dated from 26 April 2021, Memantine 20mg is not signed for as administered till 27 April 2021 and that there was a '/' for the entry on 26 April 2021 on this chart. On the third MAR chart dated from 27 April 2021, Memantine 20mg is signed as administered on 27 April 2021.

However, although the panel found that there were errors in the recording of medication administration between 26 and 27 April 2021, it considered that Ms Lea could not be

expected to have that level of oversight over such a short period of time. The panel concluded that the registered nurses at the Home were responsible for their own clinical practice and it was reasonable for Ms Lea to expect them to accurately record medication administration without the need for daily monitoring.

Accordingly, the panel determined that these charges are found not proved.

Charge 1. a. iv.

1. In respect of Service User A, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        iv. Between 8 and 27 April 2021, 2 different MAR charts were used in for Senna 7.5mg tablets, with different signatures on both charts.

This charge is found NOT proved.

The panel was provided with two documents one dated from 8 April 2021, which was SUA's MAR chart, and a second document dated from 26 April 2021 which was entitled '*Boxed medicine record chart'*. The panel determined that the second document was a record of the running total of medication and was not a MAR chart. Therefore, the fact that they had different signatures was of no significance and did not indicate a duplication of medication administration or recording. Therefore, the panel could not be satisfied that Ms Lea had failed to ensure that accurate records of medication administration were kept in respect of SUA's Senna 7.5mg tablets between 8 and 27 April 2021.

Accordingly, the panel determined that this charge is found not proved.

Charge 1. a. v. and charge 1. a. vi.

1. In respect of Service User A, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:

v. On 8 April 2021, a signature on a Senna 7.5mg MAR chart had been crossed out without note or explanation,
vi. On 11 April 2021, a signature on a Senna 7.5mg MAR chart was missing without note or explanation.

These charges are found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUA's MAR chart for week commencing 8 April 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'The signature on 8 April 2021 had been crossed out, so it is unclear if the Senna was given or not and there was a missing signature, a gap, on 11 April 201 where it is impossible to tell if the Senna were given.'*

The panel had regard to SUA's MAR chart and noted that the entry for 8 April 2021 had been crossed out and there was no entry for 11 April 2021. The panel was of the view that its observations were consistent with the evidence of Witness 1 and therefore accepted her evidence in this regard.

However, although the panel found that there were errors in the recording of medication administration on 8 and 11 April 2021, it considered that Ms Lea could not be expected to have that level of oversight over such a short period of time. The panel concluded that the registered nurses at the Home were responsible for their own clinical practice and it was reasonable for Ms Lea to expect them to accurately record medication administration without the need for daily monitoring.

Accordingly, the panel determined that these charges are found not proved.

Charge 1. a. vii.

1. In respect of Service User A, failed to ensure that:

a. Accurate records of medication administration were kept, in that:
    vii. 2 different MAR charts were used for Sinemet 12.5/50mg, MAR chart 1 covering 8 to 20 April 2021 and MAR chart 2 covering 15 to 26 April 2021, with both charts being signed on 16 to 20 April 2021.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and two of SUA's MAR charts exhibited dated from 8 April 2021 and an MAR interim chart dated from 15 April 2021.

The panel carefully considered the entries on the charts, noting that the signatures entered on both charts were the same throughout. The panel also considered that there were no discrepancies in the amount of medication administered during the period of overlap. The panel concluded that the two MAR charts were not inaccurate record keeping.

Accordingly, the panel determined that this charge is found not proved on a balance of probabilities.

Charge 1. b. i.

1. In respect of Service User A, failed to ensure that:
    b. The patient's medicines were reconciled when they were discharged from hospital, the discharge summary stating that there were no changes to their preadmission medicines, in that:
        i. Hyoscine, a prescribed medicine, was not included on the patient's MAR chart and/or a review of Hyoscine was not carried out.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the SUA's MAR chart dated from 8 April 2021 and a MAR interim chart dated from 15 April 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'SUA was discharged from hospital on 8 April 2021 and I saw that there was a failure to reconcile their medicines when they were discharged from hospital. The discharge summary stated there were no changes to their preadmission medicines, but Hyoscine tablets were not prescribed because the trust did not stock them and the discharge recommended that the GP should review if they are to continue with Hyoscine Tablets at the nursing home. Hyoscine is an antispasmodic medicine which is usually prescribed to relieve cramps in the stomach, intestines or bladder. I saw that Hyoscine was not on the MAR charts commencing from the day of admission 8 April 2021 and Staff Member S confirmed no review had been carried out as far as they were aware.*'

The panel took into account all of the MAR charts exhibited in respect of SUA, and it noted that Hyoscine was not listed as a prescribed medication on any of the MAR charts before it. The panel noted that on SUA's hospital discharge note dated 8 April 2021, it states that:

> '*note that hyoscine tablets have not been prescribed as inpatient as these are not stored at the trust- GP to review'*

The panel considered that Witness 1's CQC witness statement was consistent with her oral evidence, in which she confirmed a member of staff had told her no review had been carried out in respect SUA's Hyoscine medication. The panel therefore accepted the evidence of Witness 1.

Accordingly, the panel determined that this charge is found proved.

Charge 1. b. ii.

1. In respect of Service User A, failed to ensure that:

b. The patient's medicines were reconciled when they were discharged from hospital, the discharge summary stating that there were no changes to their preadmission medicines, in that:
    ii. Omeprazole 20mg, listed on the discharge letter, was not included on the patient's MAR chart covering 26 and 27 April 2021.

This charge is found proved.

In reaching this decision the panel took into account Witness 1's evidence and SUA's MAR chart.

The panel noted Witness 1's CQC witness statement that states:

> *'I examined SUA's MAR which covered 26 and 27 April 2021, the start of the new cycle, and saw it did not list Omeprazole 20mg capsules which had been administered daily on the previous MAR, as per their discharge.'*

The panel noted that on SUA's discharge letter dated 8 April 2021, '*Omeprazole gastro-resistant capsules, Dose 20mg oral, once a day, in the morning*'. The panel also took into account SUA's MAR chart for 26 and 27 April 2021, noting that Omeprazole 20mg capsule was not listed. The panel considered that this is supported by the evidence of Witness 1, and it was of the view that Witness 1's evidence in this regard had been clear and cogent. The panel therefore accepted the evidence of Witness 1.

Accordingly, the panel determined that this charge is found proved.

Charge 1. c.

1. In respect of Service User A, failed to ensure that:
    c. In May 2021, the patient had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC witness statement that states:

> *'I examined the MARS sheets and Meds Profiles for nine service users and saw that allergy status section was not completed for six service users (SUA, SUP, SUD, SUG, SUF, SUH). It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to.'*

The panel also took into account the exhibited MAR charts and Meds Profiles for SUA, noting that on all of these records the allergy section was incomplete. The panel determined that Witness 1's written evidence was consistent with her oral evidence. The panel accepted the evidence of Witness 1, and it was of the view that SUA had been put at risk in the absence of this important information. The panel was therefore satisfied that Ms Lea, in respect of SUA, had failed to ensure in May 2021 that SUA had an up-to-date allergy status in their notes.

Accordingly, this charge is found proved.

Charge 2. a. i. and Charge 2. a. ii.

2. In respect of Service User B, failed to ensure that:
    a. The patient's medication was administered safely, in that:
        i. Between 26 April and 5 May 2021, Aspirin and Lansoprazole were administered together when Aspirin should be administered with or just after food and Lansoprazole should be administered 30-60 minutes before food,
        ii. Between 6 and 16 December 2021, Aspirin and Lansoprazole were administered together when Aspirin should be administered with or just after food and Lansoprazole should be administered 30-60 minutes before food.

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Service User B's ('SUB') exhibited MAR charts, dated from 26 April 2021 and from 6 December 2021.

The panel noted Witness 1's witness statement that states:

> *'I examined SUB's MAR chart dated 26 April 2021. I saw that they were prescribed Aspirin 75mg daily to be taken with or just after food or a meal (usually prescribed to prevent blood clots forming) and Lansoprazole15mg capsules to be taken daily. Take 30-60 minutes before food (usually prescribed to treat or prevent stomach ulcers). I saw that the MAR chart showed that both these medicines were administered together each morning between 26 April and 5 May 2021.'*

It also states:

> '*On 16 December 2021 I examined the MAR chart for SUB who was still prescribed Aspirin 75mg and Lansoprazole15mg capsules. I saw that the MAR chart recorded that both these medicines were administered together each morning between 6 and 16 December 2021. This is a repeat of my findings during the May 2021 Inspection.*'

The panel also had regard to SUB's MAR charts stated above and it considered that both charts list Aspirin and Lansoprazole and stated that for each drug *'(ONE to be taken DAILY)*'.

The panel further noted Witness 1's statement that states:

> '*The medicines may not work effectively if they are not administered in line with the manufacturers' directions which means that SUB's health was placed at risk of developing blood clots and stomach ulcers. The Registered Manager*

confirmed to me that these medicines had been given together on those dates with no regard for the manufacturers' directions.'

During Witness 1's oral evidence, she informed the panel that the medications should have been given separately. She also explained that it was good practice to record the time that each medicine was administered to evidence that the medications were given separately and stated that she had advised the Home of this during the previous inspection. In the absence of such recording or further documentary evidence, and in light of Witness 1's consistent and credible evidence above, the panel was of the view that the medications continued to be given at the same time.

Therefore, the panel determined that Ms Lea had failed to ensure that SUB's Aspirin and Lansoprazole medication had been administered safely between on two occasions, namely, 26 April - 5 May 2021 and 6 - 16 December 2021.

Accordingly, the panel determined that these charges are found proved.

Charge 2. a. iii.

2. In respect of Service User B, failed to ensure that:
    a. The patient's medication was administered safely, in that:
        ii. In May 2021, the patient was prescribed Lansoprazole 15mg, Mirtazapine 30mg, Nicorandil 10mg, Sertraline 100mg, Simvastatin 40mg, and Zopiclone 3.75mg tablets, when a January 2021 therapy report stated that the patient required a Level 4 pureed diet, requiring no solid tablets.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's evidence, SUB's MAR charts exhibited dated from 26 April 2021 and the Ms Lea's reflective account form (undated).

Ms Lea's reflective account form states that:

> *'I did a course on Dysphagia and updated myself with the different types of food given to patients with dysphagia. I found out that this patient did not have true dysphagia initially and it was more mechanical dysphagia. He was struggling to chew properly due to Parkinson's and that his swallow reflex was normal. He was taken by his relatives for having an alcoholic drink in the pub and having sandwiches. The CQC inspector insisted he should be on a soft diet.'*

The panel had regard to Ms Lea's reflection on this specific incident, noting that she did not believe SUA had '*true dysphagia'.* The panel then took into account the documentary evidence in this case and the evidence of Witness 1 to determine whether Ms Lea's evidence was plausible and consistent with other evidence in respect of this charge.

Witness 1's CQC witness statement states that:

> '*examined the Speech and Language Therapy report dated January 2021, which stated that SUB must have a pureed diet, Level 4. The International Dysphagia Diet Standardisation Initiative (IDDSI) describes level 4 puree as a smooth texture with no lumps. Solid oral tablets and capsules could pose a choking risk. I saw that SUB was prescribed Lansoprazole 15mg capsules, Mirtazapine 30mg tablets, Nicorandil 10mg tablets, Sertraline 100mg tablets, Simvastatin 40mg tablets and Zopiclone 3.75 tablets. There was no evidence that [Ms Lea and the Registered Provider] had considered the risk or made arrangements for the medicines to be reviewed.'*

The panel also took into account SUB's MAR charts and noted that the prescribed medications listed included all of the medications listed by Witness 1. Further, SUB's Speech and Language Therapy ('SALT') report dated 8 January 2021 confirmed that a 'Pureed Diet – Level 4' was recommended. In Witness 1's oral evidence, she referred the panel to the International Dysphagia Diet Standardisation Initiative ('IDDSI') and explained that the SALT team would not make recommendations regarding SUA's

medication, however, as a result of SUA's Dysphagia, prescribed tablets would present a choking risk to the patient. The panel accepted Witness 1's evidence in respect of this and noted that this was also consistent with her written statement.

The panel considered Ms Lea's evidence that SUA did not have '*true'* dysphagia but noted there was no corroborating evidence to support this assertion. Ms Lea had not given any dates in relation to when she had realised SUA did not have true dysphagia. In addition, the panel considered the information about what SUA consumed when they went out with relatives was hearsay and it was not able to test her account. Therefore, the panel could not rely on this as evidence that SUA did not have dysphagia at the time of the CQC inspection in April 2021 and preferred both the contemporaneous documentary evidence and oral evidence of Witness 1.

Therefore, the panel determined that Ms Lea had failed to ensure that SUB's medications in May 2021 as stated in this charge, were administered safely.

Charge 2. a. iv.

2. In respect of Service User B, failed to ensure that:
    a. The patient's medication was administered safely, in that:
        iv. In December 2021, the patient was prescribed Lansoprazole 15mg, Mirtazapine 30mg, Nicorandil 10mg, Sertraline 100mg, and Carbocistein 375mg tablets, when a January 2021 therapy report stated that the patient required a Level 4 pureed diet, requiring no solid tablets.

This charge is found proved.

In reaching this decision the panel took into account its findings on respect of charge 2. a. iii, Ms Lea's reflective account form and the evidence of Witness 1.

Having determined that SUB's SALT report in January 2021 confirmed that a 'Pureed Diet – Level 4' was recommended the panel then went on to consider further evidence in respect of this charge.

The panel noted Ms Lea's reflective account form. This states:

> '*I referred the patient to SALT team again to get a better clarification. They have agreed with me and advised him to have normal diet. I have used the opportunity to ask all the Nurses, Kitchen staff and Carers to do the dysphagia course to update them. I have put up posters in the kitchen and the dining area to inform the kitchen staff about the various types of diet given to patients who may have dysphagia to prevent choking and potential respiratory infection'.*

The panel also noted Witness 1's CQC witness statement that states:

> *'In [sic] 16 December 2021 I saw that SUB must have a pureed diet, Level 4. The International Dysphagia Diet Standardisation Initiative (IDDSI) describes level 4 puree as a smooth texture with no lumps. Solid oral tablets and capsules could pose a choking risk. I saw that SUB was still prescribed Lansoprazole 15mg capsules, Mirtazapine 30mg tablets, Nicorandil 10mg tablets, Sertraline 100mg tablets. They were also prescribed Carbocisteine 375mg Capsules to be taken four times daily and some Amoxicillin capsules which were prescribed on 14 December 2021 and there still was no evidence that you [Ms Lea] had considered the risk or made arrangements for the medicines to be reviewed, despite having been warned of the risk after our inspection in May 2021.'*

The panel also had regard to a letter dated 23 December 2021 from SUB's GP practice entitled 'Query regarding suitability of chewing tablets'. The panel considered that this was in response to a query raised by a member of the staff at the Home, following the CQC April 2021 inspection. In this letter the pharmacist states:

> *'1. **Aspirin** – is a dispersible tablet so no action necessary*

*2. **Lansoprazole 15mg caps**- have switched to oro-dispersible*

*3. **Mirtazpine 30mg tablets**- Have switched to oro-dispersible*

*4. **Carbocisteine 375 caps**- Have switched to liquid*
[…]

Using Newt guidelines as reference:

*5. **Nicorandil***

The tablets can be crushed and mixed with water for administration. – Without crushing they disperse around five minutes'

Notwithstanding this change to SUB's medication, the panel considered that on SUB's MAR chart dated from 6 December 2021 demonstrated that capsule/tablets forms of the medication were prescribed as stated in the charge. The panel was of the view that this was consistent with the Witness 1's CQC witness statement and that it had no documentary evidence before it to suggest that there had been a change in SUB's condition in respect of his Dysphagia between May and December 2021 to support Ms Lea's account. The panel considered that a further SALT assessment dated 24 November 2021, confirmed that a pureed level 4 diet remained the recommendation of the SALT team.

The panel determined that Ms Lea had failed to ensure that SUB's medications in December 2021 as stated in this charge were administered safely.

Accordingly, this charge is found proved.

Charge 2. a. v.

2. In respect of Service User B, failed to ensure that:
    b. The patient's medication was administered safely, in that:

v. An unlabelled Salamol Easi-breathe inhaler was used for the patient when they were prescribed a Ventolin Evohaler.

This charge is found proved.

In reaching this decision the panel took into account the evidence of Witness 1 and SUB's exhibited Med Profile chart dated from 26 April 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'I also found an unlabelled Salamol Easi- breathe inhaler in the medicines trolley. Staff member S told me the inhaler belonged to SUB. I examined the Med Profile and saw that they were prescribed Ventolin Evohaler not a Salamol Easi-breathe inhaler and I found a Ventolin Evohaler in the stock cupboard for SUB. Staff member S told me she did not know who the unlabelled Salamol Easi- breathe inhaler was for.'*

The panel also had regard to a picture of the unlabelled Salamol inhaler and the labelled Ventolin Evohaler and that the label on this box detailed administration instructions and SUB's name. The panel also took into account SUB's Meds Profile chart which confirmed that SUB had been prescribed a Ventolin Evohaler.

The panel considered the evidence of Witness 1, and accepted that staff member S, a registered nurse at the Home, had confirmed that the Salamol Easi- breathe inhaler had been used for SUB at the time of the April 2021 CQC inspection. The panel noted that there was no evidence to support that the correct inhaler had been used.

The panel determined that Ms Lea had failed to ensure SUB's medication was administered safely, in that, an unlabelled Salamol Easi-breathe inhaler was used for the patient when they were prescribed a Ventolin Evohaler.

Accordingly, this charge is found proved.

Charge 2. a. vi. 1-7.

2. In respect of Service User B, failed to ensure that:
    a. The patient's medication was administered safely, in that:
        vi. On 24 November 2021, a Speech and Language Therapy ('SALT') assessment stated that the patient required a Level 2 pureed diet, which was not followed on 1 or more of the following occasions:
            1. 20.11.21 at 14:44,
            2. 21.11.21 at 11:51,
            3. 25.11.21 at 20:50,
            4. 27.11.21 at 17:44,
            5. 28.11.21 at 14:43,
            6. 30.11.21 at 18:10,
            7. 09.12.21 at 12:57.

These charges are found NOT proved.

In reaching this decision the panel took into account the evidence of Witness 2 and SUB's SALT report dated 8 January 2021 and 24 November 2021.

The panel noted Witness 2's CQC witness statement that states:

> *'I saw SUB had been re-assessed by the Speech and Language Therapy Team (SALT) on 06 July 2021 and the 24 November 2022. In July 2021, the SALT team advised for SUB to be given a pureed diet with Level 1 thicken fluids with one scoop of Nutilus Clear powder (thickening medication) to be added to SUB's drinks per 200mls of fluid. In November 2022, however, this advice had changed with SUB requiring Level 2 thickened fluids with two scoops of Nutilus Clear Poweder [sic] to be added to 200mls of fluid.'*

The panel also had regard to Witness 1's CQC witness statement that states:

> *'I examined the Speech and Language Therapy report dated January 2021, which stated that SUB must have a pureed diet, Level 4. The International*

Dysphagia Diet Standardisation Initiative (IDDSI) describes level 4 puree as a smooth texture with no lumps.'

The panel had regard to the charge, noting that it states SUB was required to have *'a Level 2 pureed diet'.* However, the panel was of the view that this did not reflect the evidence of witnesses 1 and 2, in that Witness 1 confirms that SUB's must have a '*pureed diet, Level 4'* and Witness 2 refers to '*Level 2 thicken fluids'.*

The panel bore in mind that the burden of proof rests upon the NMC and that the evidence provided did not support the assertion in the charge that the SALT report of 24 November said that SUB required a Level 2 pureed diet. The report states he required a Level 4 pureed diet. Therefore, the panel did not find this charge proved.

Charge 2. b. i.

In respect of Service User B, failed to ensure that:

b. Accurate records of medication administration were kept, in that:
    i. Between 8 November and 20 December 2021, the patient was administered 70 doses of Trimblow inhaler, when their MAR chart recorded the administration of 168 doses.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUB's MAR chart dated from 6 December 2021.

The panel noted Witness 1's CQC witness statement that states:

'I saw that SUB was prescribed Trimbow inhaler; two puffs to be inhaled twice daily (usually prescribed for the treatment of chronic obstructive pulmonary disease (COPD)). The inhaler was marked as opened on the 8 November 2021 at 8am. I attach as Exhibit AF/88 SUB's Trimbow inhaler which was opened 8 November 2021. On 20 December I observed there were 50 doses remaining in the inhaler. A full inhaler contains 120 doses, this means that 70 doses have

been given since the inhaler was opened 8 November 2021. I examined the MARS for this period and I confirmed with Karen Lea that it was recorded that this inhaler had been given each day since it was opened, a period of 42 days is 168 "puffs".'

The panel also had regard to the picture of SUB's Trimbow inhaler which evidenced 50 doses remaining in the inhaler. The panel noted that on MAR chart it states that: '*TWO PUFFS to be inhaled TWICE a day'* therefore, four puffs were to administered per day. The panel also noted that the date recorded for the inhaler being opened is November 2021 and accordingly, if the inhaler was administered correctly, a total of 168 puffs would have been given to SUB.

The panel acknowledged that it did not have sight of SUB's MAR chart for the period of 8 November to 6 December 2021, but the panel had been provided with a MAR chart covering the period from 6 December - 19 December 2020 and it had sight of the administration instructions on the box of the inhaler requiring *TWO PUFFS to be inhaled TWICE a day' and the picture of the Trimbow inhaler with a box to indicate the remaining 50 doses.* The panel noted that Ms Lea in her written submissions made no reference or challenge to this charge. Therefore, the panel accepted the evidence of Witness 1 in relation to this charge.

Accordingly, the panel determined that this charge is found proved.

Charge 2. b. ii.

In respect of Service User B, failed to ensure that:

b. Accurate records of medication administration were kept, in that:

ii. On 13 December 2021, at 9:30am, a PRN Salbutamol nebule was administered, and at 10:00am, a PRN Ventolin Evohaler dose was administered, with no rationale recorded for the administration of both PRN medicines in half an hour.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUB's PRN (as required) charts exhibited dated from 6 December 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'I saw the MAR chart recorded that on the 13 December 2021 they were given nebule at 10:00 am and the inhaler at 10:30 am. On the 16 December 2021 they were given nebule at 9:30am and the inhaler at 10:00 am. There was no record to explain the rationale behind their decision to administer the doses close together or any information about the effectiveness or the time it was monitored.'*

The panel also had regard to SUB's MAR chart which confirmed that SUB's PRN Ventolin Evohaler was administered half an hour after the PRN Salbutamol nebule. The panel did not identify any records providing a rationale for this. However, the panel was not provided with a reason why a rationale was required. In the absence of evidence to explain why a rationale was required and how the absence of the rationale would make the records inaccurate, the panel did not find this charge proved.

Charge 2. b. iii.

In respect of Service User B, failed to ensure that

b. Accurate records of medication administration were kept, in that:
    iii. On 13, 14, and/or 16 December 2021, PRN Ventolin Evohaler was administered without a record of medical advice sought for the administration of the medicine.

This charge is found NOT proved.

In reaching this decision the panel took into account SUB's PRN charts exhibited dated from 6 December 2021.

The panel took into account Witness 1's CQC witness statement that states:

'The MARS shows that the inhaler was administered on 13,14 and 16 December 2021, but there was no recoded [sic] information to show that medical advice had been sought as per the PRN protocol.'

The panel had regard to SUB's Ventolin Evohaler PRN protocol, dated 25 October 2021. The panel noted that the PRN protocol states to seek medical advice if the inhaler is given *'more than 4 times in 24 hours more than twice a week'.* The panel viewed the MAR chart for SUB and noted that Ventolin was administered once on 13,14 and 16 December 2001. The panel noted that there was no evidence to suggest that medical advice was sought. The panel concluded that there was no requirement to do so as it was a PRN medication and it was not given more than 4 times in 24 hours therefore, it follows that the records accurately reflected this.

Accordingly, the panel determined that this charge is found not proved.

Charge 2. c. i.

In respect of Service User B, failed to ensure that:

c. PRN protocols were adequate, in that:

i. The patient was prescribed a Ventolin Evohaler, when the PRN protocol did not include information on how to assess the need for the inhaler, and/or its maximum dose, and/or its use alongside other PRN medicine.

This charge is found proved.

The panel took account of Witness 1's statement that states:

'the PRN protocol for the Ventolin Evohaler was limited in scope. I attach as Exhibit AF/99 SUB's Ventolin Evohaler PRN Protocol. The plan detailed they had asthma and COPD and can be wheezy and breathless at times but gave no information how to assess their need for the inhaler. The plan did not state that they were prescribed the same drug in another formulation, it did not address

which formulation to use initially. The maximum number of inhalations/ days is eight 'puffs' and the maximum daily dose for salbutamol nebules is 20mg, unless under medical supervision in hospital. If a combination of formulations is used, then the total dose of salbutamol must be considered so that the service user does not experience symptoms of overdose. There was information that the maximum number of doses each day was four and the minimum time between doses was four hours. There was no information about the use of the inhaler if the doses were not effective in relieving the asthma attack'

In her oral evidence, Witness 1 accepted that the PRN protocol did say that the inhaler should be used if SUB was '*wheezy or breathless'* and that it outlined the maximum dose and how often it could be taken. Therefore, the panel did not find the first two parts of the charge proved. The panel noted there was no reference to other PRN medicines in the Ventolin protocol and therefore the panel found this part of the charge proved.

Charge 2. c. ii.

2. In respect of Service User B, failed to ensure that:
    c. PRN protocols were adequate, in that:
        ii. The patient was prescribed Salbutamol Nebules and there was no PRN protocol in place for this medicine.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's evidence and SUB's PRN chart dated from 6 December 2021.

The panel considered that SUB's PRN chart for this medication evidenced that Salbutamol Nebules were prescribed as PRN medication. However, the panel had careful regard to the bundle and noted that there was no PRN protocol contained within it for Salbutamol Nebules.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 2. d. i.

2. In respect of Service User B, failed to ensure that:
    d. Patient records were adequate, in that:
        i. The patient's type of dementia and/or how it affected their health was not recorded.

This charge is found NOT proved.

In reaching this decision, the panel took into account SUB's Cognition (Memory) Care plan created on 28 April 2016 and last updated on 10 December 2021.

The panel noted that on this plan, SUB's type of dementia is not recorded, however, the panel was of the view that the plan gives clear guidance how to communicate with SUB and what actions should be taken for example: '*he is encouraged to try and talk about his past and carers should actively engage in conversations about his family and home life and work*'.

The panel was of the view that SUB's Cognition (Memory) Care plan was not inadequate in that it stipulated mechanisms to keep him mentally active, maintain his mental health through de-escalation and reassurance during daily activities.

Accordingly, the panel determined that this charge is found not proved.

Charge 2. d. ii.

2. In respect of Service User B, failed to ensure that:
    d. Patient records were adequate, in that:
        ii. On 8 January 2021, the patient was diagnosed with Dysphagia, but records lacked information on patient support.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUB's Nutrition Care Plan created on 28 April 2016 and last updated on 10 December 2021.

The panel noted Witness 2's CQC witness statement that states:

> *'Staff lacked clear and up to date information about the support SUB required In order to mitigate the risk of choking.'*

The panel also had regard to SUB's Nutrition Care Plan that states '*Oropharyngeal dysphasia [sic] detected'.* The panel noted that the plan included information regarding how to position SUB both during mealtimes and for 30 minutes after. Further the plan details that SUB requires a 'Pureed Diet – Level 4' and that 'Supervision/ Assistance required' amongst other relevant information. The panel determined that this plan was adequate in that it provided clear guidance on how to support SUB's Dysphagia.

Accordingly, the panel determined that this charge is found not proved on a balance of probabilities.

Charge 2. d. iii.

2. In respect of Service User B, failed to ensure that:
    d. Patient records were adequate, in that:
        iii. Contradictory SALT assessments were included in the care plan.

This charge is found proved.

In reaching this decision the panel took into account Witness 2's evidence and SUB's Nutrition Care Plan, created on 28 April 2016 and last updated on 10 December 2021.

'When I looked at SUB's nutrition and hydration care plan dated 10 December 2021, however, it contained two sets of contradictory advice on the amount of thickening medication to be added to SUB's drinks and the level of consistency safe for them to consume. In one section of the care plan, staff were advised to thicken SUB's fluids drinks to a consistency of Level 1 thicken fluids. This corresponded with the advice given in July [sic] 2021. Yet in another section, it stated for SUB's drinks to be thickened to a Level 2 thicken consistency (two scoops of Nutilus Clear per 200mls) to protect them from choking. This corresponded to the most up to date advice given by SALT in November 2021. The old advice in SUB's care plan had not been removed which was very confusing.'

The panel also considered that Witness 2's written evidence was also supported by her oral evidence in which she confirmed she had sight of SUB's Nutrition and Hydration Care Plan and that the advice was conflicting. The panel accepted Witness 2's evidence in this regarding noting that in SUB's care plan which had been approved by Ms Lea, included both sets of advice from the SALT in both January and November 2021 but it was not clear which was the current advice therefore it was contradictory and confusing.

Accordingly, the panel determined that this charge is found proved.

Charge 2. d. iv.

2. In respect of Service User B, failed to ensure that:
    d. Patient records were adequate, in that:
        iv. The COVID-19 risk assessment was not specific to the patient.

This charge is found NOT proved.

The panel had careful regard to the exhibit bundle, and noted it had not been provided with the COVID-19 risk assessment for SUB. Therefore, the panel was unable to ascertain whether, in respect of SUB Ms Lea failed to ensure that SUB's records were adequate in that their COVID-19 risk assessment was not specific to the patient.

Accordingly, the panel determined that this charge is found not proved.

Charge 2. e. i.

2. In respect of Service User B, failed to ensure that:
    e. Capacity assessments were adequate, in that:
        i. Capacity assessments carried on 7 July and 10 December 2021 did not identify specific issues for which capacity had been assessed.

This charge is found proved in part.

In reaching this decision, the panel took into account SUB's mental capacity assessment dated 7 July 2021 and a document entitled 'Consent to Care and Treatment Care Plan', last updated on 11 December 2021.

The panel noted that it only had one mental capacity assessment before it in respect of SUB. The panel also took into account that the document referred to in Witness 2's witness statement entitled 'Consent to Care and Treatment Care Plan' stated that:

> '*A mental capacity assessment has been completed and he lacks capacity to retain information and make long term decisions'*

The panel noted that this plan makes reference to a capacity assessment taking place on 11 December 2021, however the panel did not have sight of the documentation from this assessment. The panel then considered the document before it in relation to 7 July 2021, noting that the assessment had been completed by Ms Lea. The panel was of the view that the document lacked detail in that it did not identify specific issues for which capacity had been assessed. The panel therefore concluded that Ms Lea had failed to ensure that SUB's capacity assessment was adequate, in that it did not identify specific issues for which capacity had been assessed.

Accordingly, the panel determined that this charge is found proved in relation to the mental capacity assessment of 7 July 2021, but not the mental capacity assessment of 10 December 2021.

Charge 2. e. ii.

2. In respect of Service User B, failed to ensure that:
    e. Capacity assessments were adequate, in that
        ii. On 7 July 2021, a capacity assessment and bed rail capacity assessment were conducted, when they should not have been carried out on the same day.

This charge is found NOT proved.

In reaching this decision the panel took into account the evidence of Witness 2, SUB's assessment of mental capacity and assessment of mental capacity for bed rails both dated 7 July 2021.

The panel noted Witness 2's CQC witness statement that states:

> *'SUB's care file contained a capacity assessment pertaining to bed rails on the same day, 07 July 2021. This was not good practice. Conducting multiple capacity assessments on the same day at the same time does not show that [Ms Lea and the Registered Provider] have fully understood the principles of the MCA or that they had considered that multiple, simultaneous assessments are confusing and tiring for people to participate in, which may impact on their ability and motivation to respond.'*

The panel also noted Witness 2's oral evidence, in which she accepted that both these assessments could be done in a day, by completing one assessment and returning at a later time to carry out the other assessment. The panel determined that Witness 2's evidence in this regard was inconsistent with her written statement. The panel was not presented with any evidence to suggest SUB was not able to manage two assessments

in one day and although not best practice the panel did not find this rendered the assessments inadequate. In the absence of any further evidence to support that these capacity assessments should not have been carried out on the same day, the panel could not be satisfied that Ms Lea had failed to ensure that SUB's capacity assessments were adequate in this regard.

Accordingly, the panel determined that this charge is found not proved.

Charge 2. e. iii.

2. In respect of Service User B, failed to ensure that:
    e. Capacity assessments were adequate, in that:
        iii. The consent plan did not include the patients consent and/or included conflicting information relating to their capacity,

This charge is found NOT proved.

In reaching this decision the panel took into account SUB's Consent to Care and Treatment plan, dated 10 December 2021.

The panel first considered whether the consent plan included the patient 's consent. The panel noted that the plan states:

> '*SUB is able to consent to simple day to day activities but due to his dementia is unable to make informed decisions easily and so is unable to consent to his ongoing care and treatment […] SUB is to be encourages[sic] to make decisions that affect his care'.*

The panel noted that the outcome of SUB's mental capacity assessment was recorded in the consent plan, that they could not provide consent to their care and treatment. Therefore, the panel concluded that in this regard, the consent plan was adequate in that SUB's inability to consent was recorded.

The panel then considered whether the consent plan included conflicting information relating to SUB's capacity. The panel accepted that the consent plan records that SUB has capacity to make some decisions but not others. Although this could be considered contradictory the panel is aware this is the reality for many service-users living with dementia and therefore did not consider it to be conflicting information in this context.

Therefore, the panel found this charge not proved.

Charge 2. f. i.

2. In respect of Service User B, failed to ensure that:

f. The Personal Emergency Evacuation Plan ('PEEP') was adequate, in that it

i. Was not dated.

This charge is found proved.

In reaching this decision, the panel had regard to SUB's PEEP, noting that there was no dated recorded other than the date of the patient's admission.

Accordingly, the panel determined that this charge is proved.

Charge 2. f. ii. and iii.

2. In respect of Service User B, failed to ensure that:

f. The Personal Emergency Evacuation Plan ('PEEP') was adequate, in that it:

ii. Contradicted other capacity records,

iii. Made no reference to Deprivation of Liberty safeguards.

These charges are found NOT proved.

2f. ii.

In reaching this decision, the panel took into account SUB's PEEP.

The panel noted that the plan details SUB's personal physical and neurological considerations in the event of an emergency evacuation. It also outlines any other general medical issues that should be considered. The panel noted it said in the PEEP;

> '*SUB may understand the need to evacuate in the event of a fire but can be to [sic] resistive to being moved as he has Dementia'.*

The panel did not consider this to be contradictory with the other capacity records that it had seen in relation to SUB as those records noted differing levels of capacity relating to different types of decisions.

2f.iii.

The panel further noted that it does make reference to Deprivation of Liberty safeguards ('DoLs') as it states '*DoLs in place'*. Witness 1 conceded this in her oral evidence. Therefore, the panel determined that SUB's PEEP plan was adequate in this regard.

Accordingly, the panel determined that these charges are found not proved.

Charge 2. g. i.

2. In respect of Service User B, failed to ensure that:

g. The Nutrition Care Plan was adequate, in that:

i. It stated the patient required fluids of 1,200-1,500mls per day, and 1,500-2,000mls per day.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUB's Nutrition Care Plan created 28 April 2016 and last updated 10 December 2021.

The panel noted that in the '*Action'* part of the plan, it states:

'he needs input between 1200-1500mls in 24 hrs

[…]

Aim for a daily intake of 6-8 drinks of 250mls'

The panel noted that the later entry contradicted the earlier entry, in that the upper limit of SUB's daily intake is 500mls greater. However, the panel was of the view that this discrepancy did not make the nutrition plan inadequate.

Accordingly, the panel determined that this charge is found not proved on a balance of probabilities.

Charge 2. g. ii. 1-7.

2. In respect of Service User B, failed to ensure that:

g. The Nutrition Care Plan was adequate, in that:

ii. The patient's weight was to be recorded monthly, but was not recorded on 1 or more of the following months:

1. November 2020,
2. December 2020,
3. January 2021,
4. March 2021,
5. April 2021,
6. June 2021,
7. August 2021.

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUB's Nutrition Care Plan.

The panel noted Witness 2's CQC witness statement that states:

> *'SUB's nutritional care plan stated that SUB's weight must be monitored monthly. Yet SUB's weight records were completed sporadically and insufficiently to enable staff to quickly identify and mitigate risks associated with malnutrition. For example, in the last 18 months, [Ms Lea and the Registered Provider] had failed to ensure that SUB's weight was taken in November 2020, December 2020, January 2021, March 2021, April 2021, June 2021 and August 2021. In February 2021, SUB's weight and BMI was recorded as 71.2kgs (11st 3llbs) and 26.2 respectively. '*

The panel had regard to SUB's Nutrition Care Plan that states:

> *'SUB's weight to be checked when he is agreeable at least monthly*
>
> *[…]*
>
> *Monitor his weight monthly and record'*

The panel also had regard to SUB's weight statistics recorded between 1 May 2020 to 16 December 2021. It noted that there were no entries for all of the months set out in the charges above. The panel considered that this was consistent with the evidence of Witness 2 and it accepted her evidence in respect of these charges.

Accordingly, the panel determined that these charges are found proved on a balance of probabilities.

Charge 2. g. iii.

2. In respect of Service User B, failed to ensure that:

g. The Nutrition Care Plan was adequate, in that:

iii. In February 2021, the patient's weight was recorded at 71.2kgs, and in November 2021 at 63.3kgs, but no explanation was given for the 7.9kgs weight loss.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUB's Nutrition Care Plan.

The panel noted Witness 2's CQC witness statement that states:

> *'In February 2021, SUB's weight and BMI was recorded as 71.2kgs (11st 3llbs) and 26.2 respectively. In November 2021, SUB's weight was recorded as 63.30kgs (9st 14llbs) and BMI 23.25, indicating a weight loss of 7.9kgs (1st 3llbs). There was no explanation for this weight loss in his care file.'*

It also states that:

> *'I asked Karen Lea during the inspection on the 20 December 2021 about SUB's weight loss and whether a referral to the dietitian had been made. [Ms Lea] did not know.'*

The panel had regard to SUB's weight statistics, noting that the patient's weight had been recorded in February 2021 as 71.2kgs and in November 2021 as 63.3kgs. The panel also noted that within these records, there was no explanation given for SUB's weight loss in February and November 2021. The panel considered that this was consistent with Witness 2's evidence and supported by the patient's records. In all the circumstances, the panel concluded that Ms Lea failed to ensure the Nutrition Care Plan was adequate in that no explanation was recorded for SUB's weight loss in February and November 2021.

Accordingly, the panel determined that this charge is proved on a balance of probabilities.

Charge 2. h. i.

2. In respect of Service User B, failed to ensure that:
    h. Daily records were adequate, in that:
        i. Between 1 November and 16 December 2021, Vital Statistic Records for fluid intake did not always include the specific amount of fluid consumed.

This charge is found NOT proved.

In reaching this decision, the panel took into account SUB's Vital Statistic Records for fluid intake dated 1 November - 16 December 2021. The panel found that on a very limited number of records the amount of fluid intake was not clear. However, in general the notes did record the specific amount of fluid given and consumed with a daily total recorded. Therefore, the panel did not find that Ms Lea failed to ensure that the daily records were adequate in relation to always recording the specific amount of fluid consumed in the Vital Statistic Records.

Accordingly, the panel determined that this charge found not proved.

Charge 2. h. ii. and iii.

2. In respect of Service User B, failed to ensure that:
    h. Daily records were adequate, in that:
        ii. On 1 December 2021, the quantity of food served and/or eaten was not recorded,
        iii. On 2 December 2021, at lunchtime, the quantity of food served and/or eaten was not recorded.

These charges are found NOT proved.

In reaching this decision, the panel took into account SUB's daily records dated from 1 November – 16 December 2021.

The panel had regard to the entries for 1 and 2 December 2021 and accepted that the amount of food served on either date had not been recorded and on some occasions the amount of food eaten had not been recorded.

The panel noted Witness 2's CQC witness statement, that states:

> *'For example, on the 01 December 2021, staff had simply recorded what food SUB had been served with at each mealtime and had not recorded how much SUB had eaten. On the 02 December 2021, the amount of food eaten by SUB at lunchtime was not recorded. It was impossible to know therefore if he had eaten anything at these mealtimes.'*

The panel did not have any evidence regarding the expected standards of recording patient's food intake and therefore, it was unable to ascertain what adequate recording of a patient's food served and eaten would look like. The panel considered that the NMC had not adduced any further evidence in respect of this charge, and in the absence of such evidence, the panel determined that this charge is not found proved on a balance of probabilities.

Charge 2.i. i. and ii.

2. In respect of Service User B, failed to ensure that:
    i. Temperature check records were adequate, in that:
        i. They did not consider COVID-19,
        ii. The only checks covering January and February 2021 took place on 27 and 28 February 2021.

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUB's temperature check records dated from 8 July 2020 to 16 December 2021.

The panel noted Witness 2's CQC witness statement. She states:

> *'When I looked at people's vital statistics records and temperature records, I found that people's vital statistics such as temperature, pulse, blood pressure etc., were not regularly taken to monitor for early signs of ill health or COVID-19. The Government guidelines at the time of both inspection in April and December 2021 clearly advised health and social care providers to ensure that people living in a care home had a COVID-19 PCR test every 28 days and their temperature checked twice a day. Yet despite this, [Ms Lea and the Registered Provider] had not ensured that these checks were made. For example, I checked SUB's and SUW's care file for evidence a PCR test had been taken every 28 days and that their temperature had been monitored twice a day. I found these checks had not been completed.'*

The panel accepted the evidence of Witness 2, as it was of the view that her written statement was consistent with her oral evidence. Further, the panel found that Witness 2's evidence was supported by the documentation before it, which confirmed that SUB's temperature had not been taken and monitored twice a day, as advised and in accordance with government guidelines.

The panel also noted in Witness 2's statement that she stated:

> *'temperature checks January 2021 to December 2021 were poor and showed that [Ms Lea and the Registered Provider] had paid no regard to monitoring SUB's temperature for COVID-19. For example, I found that there were no temperature monitoring records for January 2021 and SUB's temperature in February 2021 had only been taken once on 27 and 28 February 2021.'*

The panel had regard to SUB's temperature check records, and the panel noted that there were only two recordings covering January and February 2021, namely, on 27

February 2021 at 18:38 and on 28 February 2021 at 06:20. The panel concluded that Ms Lea had failed, in respect of SUB to ensure their temperature check records were adequate, in that, they did not consider COVID-19 and their temperature was only taken on 27 and 28 February 2021, during January and February 2021.

Accordingly, the panel determined that these charges are found proved on a balance of probabilities.

Charge 3. a. i.

3. In respect of Service User D, failed to ensure that:
    a. Latanoprost eye drops were administered appropriately, in that,
        i. On 7, 21, and 23 April 2021, the patient's topical daily chart was not signed to show the eye drops had been administered.

This charge is found NOT proved.

In reaching this decision, the panel took into account Service User D's ('SUD') topical daily chart dated from 29 March 2021.

The panel had regard to the chart and noted that it was not signed to show the eye drops had been administered on the dates as set out in the charge. The panel considered that the administration instructions for the eye drops are:

'ONE drop DAILY into BOTH eyes'

The panel noted that the eye drops had not been recorded as administered on 7, 21 and 23 April 2021. However, although the panel found that there were errors in the administration of medication on 7, 21 and 23 April 2021, it considered that Ms Lea could not be expected to have that level of oversight over such a short period of time. The panel concluded that the registered nurses at the Home were responsible for their own clinical practice and it was reasonable for Ms Lea to expect them to accurately administer medication without the need for daily monitoring.

Accordingly, this charge is found not proved.

Charge 3. a. ii.

3. In respect of Service User D, failed to ensure that:
    a. Latanoprost eye drops were administered appropriately, in that,
        ii. The eye drops were stored in a stock cupboard prior to opening, when they need to be stored at 2-8°C.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC witness statement, that states:

> *'I saw that medicines which required cold storage were not stored safely because the fridge temperatures were not monitored correctly, and the thermometer did not provide accurate readings. I also saw that medicines which needed to be stored in the fridge had been stored at room temperature. I found four unopened bottles of Latanoprost eye drops dispensed in February 2021 for SUD were stored at room temperature in the stock cupboard.'*

The panel had regard to the photograph of the Latanoprost Eye Drops for Service User D ('SUD') taken and exhibited by Witness 1. The panel noted that on the box it states, '*store in a refrigerator (2°C -8°C)'.* The panel considered that the photograph evidences that these eye drops were not in the fridge, further it accepted the evidence of Witness 1 as it her written statement was consistent with her oral evidence in this regard.

Witness 2's CQC witness statement also states:

'*If Latanoprost drops are not stored at the correct temperatures, they may no longer be effective and SUD's eyesight was placed at risk of harm. Appendix 64 shows a photograph of Latanoprost Eye Drops for SUD.'*

The panel was of the view that the medication had not been stored in accordance with the manufacturer's directions and therefore would not be appropriate for administration.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 3. b.

3. In respect of Service User D, failed to ensure that:
    b. Co-codamol 15/500mg were given regularly or a PRN protocol for its administration was put in place.

This charge is found NOT proved.

In reaching this decision the panel took into account the evidence of Witness 1 and SUD's MAR charted dated from 26 April 2021.

The panel noted Witness 1's CQC witness statement that states:

'SUD was prescribed Co-codamol tablets 15/500mg tablets. The printed MAR dated 26 April 2021 showed the prescribed dose was two "up to" four times a day. The direction "up to" indicates this was not prescribed as regular dose. However, the label on the box dispensed 19 August 2020 stated; two tablets to be taken four times daily and was not prescribed "when required". The MAR shows despite the prescriber's directions it was treated as if it was prescribed when required and was not given regularly. I saw there was no protocol in place on the day of the inspection to support this.'

The panel noted that there was no PRN protocol in respect of SUD's Co-codamol 15/500mg medication. However, the panel was of the view that a PRN protocol was not

required as the medication had not been prescribed as a PRN medication, but as a regular dose. The panel noted that Witness 2 had explained in her oral evidence that the MAR charts would be printed out by the pharmacist and the instruction on the MAR chart were '*two up to four times a day'*. Further the panel considered SUD's MAR chart and noted that the medication had been administered between one to four times a day everyday between 26 April to 4 April 2021, in accordance with the instructions on the MAR chart.

In all the circumstances, the panel could not be satisfied that Ms Lea had failed to ensure that Co-codamol 15/500mg were given regularly or a PRN protocol for its administration was put in place.

Accordingly, the panel determined that this charge is not found proved on a balance of probabilities.

Charge 3. c.

3. In respect of Service User D, failed to ensure that:
    c. In May 2021, the patient had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC statement that states:

> *'I examined the MARS sheets and Meds Profiles for nine service users and saw that allergy status section was not completed for six service users (SUA, SUP, SUD, SUG, SUF, SUH). It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to*.'

The panel noted that Witness 1's evidence was also consistent with her oral evidence. The panel had regard to all of the MAR charts and Med Profiles in respect of SUD and noted that there was nothing recorded in the allergies or notes section. In the absence of any further documentation to undermine this, the panel concluded that Ms Lea failed to ensure in May 2021, that SUD had up-to-date allergy status in their notes.

Accordingly, the panel determined that this charge is found proved.

Charge 4. a. i.

4. In respect of Service User F, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        i. The medication profile showed that no Paracetamol 500mg had been sent, received, or brought forward, when 86 tablets were dispensed on 15 December 2020 and/or 32 tablets were dispensed on 20 August 2020.

This charge is found proved.

In reaching this decision the panel took into account the evidence of Witness 1 and Service User F's ('SUF') Med Profile sheet dated 26 April 2021, showing Paracetamol 500mg.

The panel noted Witness 1's CQC witness statement:

> *'I examined SUF's Med Profile Sheet, dated 26 April 2021, which showed that no Paracetamol 500mg tablets had been recorded as sent, received or brought forward from a previous cycle. However, I saw that there was a box containing 86 Paracetamol 500mg tablets dated as dispensed 15 December 2020 and a box of 32 Paracetamol Caplets 500mg dated as dispensed 20 August 2020 in the stock cupboard, demonstrating the records were inaccurate.'*

Witness 1 explained in her oral evidence that an accurate record of this medication would show there was Paracetamol in stock on SUF's Med Profile sheet, however when asked during the CQC inspection, Ms Lea could not account for the extra boxes of Paracetamol.

The panel had regard to SUF's Med Profile sheet and noted that there was no record of Paracetamol 500mg being sent, received or brought forward for 26 April 2021. The panel also had sight of the photograph taken by Witness 1 during the April 2021 CQC inspection, showing a box containing 86 Paracetamol 500mg tablets dated as being dispensed on 15 December 2020 and a box of 32 Paracetamol Caplets 500mg dated as being dispensed on 20 August 2020. The panel accepted the evidence of Witness 1, as it was consistent with the documentary evidence before it. The panel concluded that there was Paracetamol dispensed for SUF in stock at the Home and therefore, SUF's Med Profile was not an accurate record.

Accordingly, the panel determined that this charge is found proved.

Charge 4. a. ii.

4. In respect of Service User F, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        ii. The medication profile showed that no Co-codamol 30/500mg had been sent, received, or brought forward, when 88 tablets were dispensed on 3 October 2020.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUF's Med Profile dated 26 April 2021, showing Co-codamol 30/500mg.

The panel noted Witness 1's CQC witness statement:

'I also saw that their Med Profile sheet dated 26 April 2021, showed that no Co codamol Effervescent tablets 30/500mg had been recorded as sent, received or brought forward from a previous cycle. I saw that there was a box of Co-codamol Effervescent tablets 30/500mg dated as dispensed 3 October 2020, containing 88 tablets, in the stock cupboard, demonstrating that the records were inaccurate. I attach as Exhibit AF/3 a photograph of SUF's Med Profile dated 26 April 2021 for Co-Codamol. I attach as Exhibit AF/4 a photograph of SUF's Co-codamol dated 3 October 2020.'

The panel had regard to SUF's Med Profile sheet and noted that there was no record of Co-codamol Effervescent tablets 30/500mg as being sent, received or brought forward for 26 April 2021. The panel also had sight of the photograph taken by Witness 1 during the April 2021 CQC inspection, showing a box of Co-codamol Effervescent tablets 30/500mg dated as dispensed on 3 October 2020, containing 88 tablets. The panel accepted the evidence of Witness 1, as it was consistent with the documentary evidence before it. The panel concluded that there was Co-codamol Effervescent tablets 30/500mg in stock for SUF at the Home and therefore, SUF's Med Profile was not an accurate record.

Accordingly, the panel determined that this charge is found proved.

Charge 4. a. iii.

4. In respect of Service User F, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        iii. The medication profile showed that no PEPTAC liquid had been sent, received, or brought forward, when it had been dispensed on 27 November 2020.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUF's Med Profile sheet dated 26 April 2021, showing Peptac liquid.

The panel noted Witness 1's CQC witness statement:

> '*On 5 May 2021, I saw that an open bottle of Peptac Liquid, dispensed on 27 November 2020 and labelled for SUF […] However, the Med Profiles dated 26 April 2021 showed that no stock had been recorded as sent, received or brought forward.'*

The panel had regard to SUF's Med Profile sheet and noted that there was no record of Peptac liquid as being sent, received or brought forward for 26 April 2021. The panel also had sight of the photograph taken by Witness 1 during the April 2021 CQC inspection, showing an open bottle of Peptac liquid dated as dispensed for SUF, on 27 November 2020. The panel accepted the evidence of Witness 1, as it was consistent with the documentary evidence before it. The panel concluded that there was Peptac liquid for SUF in stock at the Home and therefore, SUF's Med Profile was not accurate record.

Accordingly, the panel determined that this charge is found proved.

Charge 4. a. iv.

4. In respect of Service User F, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        iv. The medication profile showed that no Cosmocol sachets had been sent, received, or brought forward, when 28 sachets had been dispensed on 24 December 2020.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUF's Med Profile sheet dated 26 April 2021, showing CosmoCol Orange Flavour oral powder sachets.

The panel noted Witness 1's CQC witness statement:

> *'On 5 May 2021, I saw that […] 28 x Cosmocol sachets, dispensed on 24 December 2020, were in stock. However, the Med Profiles dated 26 April 2021 showed that no stock had been recorded as sent, received or brought forward'*

The panel also had regard to SUF's Med Profile sheet and noted that was no record of CosmoCol Orange Flavour oral powder sachets as being sent, received or brought forward for 26 April 2021. The panel also had sight of the photograph taken by Witness 1 during the April 2021 CQC inspection showing 28 CosmoCol Orange Flavour oral powder sachets dispensed for SUF. The panel accepted the evidence of Witness 1, as it was consistent with the documentary evidence before it. The panel concluded that there was CosmoCol oral powder sachets in stock at the Home for SUF and therefore, SUF's Med Profile was not an accurate record.

Accordingly, the panel determined that this charge is found proved.

Charge 4. a. v.

4. In respect of Service User F, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        v. The medication profile showed that no Glucose 40% oral gel had been sent, received, or brought forward, when 3 25g tubes were in stock on 5 May 2021.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUF's Med Profile sheet dated 26 April 2021, showing Glucose 40% oral gel.

The panel noted Witness 1's CQC witness statement:

'I saw that SUF's Med Profile Sheet also showed that no Glucose 40% oral gel was in stock, however, I found there were 3 x 25g tubes of gel were in stock. This further demonstrates the inaccuracy of the records in place. I attach at Exhibit AF/10 SUF's Med Profile Sheet dated 26 April 2021 showing the Glucose.'

The panel also had regard to SUF's Med Profile sheet and noted that there was no record of Glucose 40% oral gel as being sent, received or brought forward for 26 April 2021. The panel was not provided with a photograph of the 3 x 25 g tubes of Glucose 40% oral gel, however, it did have sight of SUG's Med Profile. In the absence of any further evidence to undermine Witness 1's findings, the panel was of the view that Witness 1 had found the 3 x 25 g tubes of Glucose 40% oral gel in stock at the Home dispensed for SUF and therefore, SUF's Med Profile was not an accurate record.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 4. a. vi. and 4. a. vii.

4. In respect of Service User F, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        vi. On 2 September 2020, the medicines record chart for Co-drydramol 10/500mg showed 98 tablets in stock, leaving 45 tablets unaccounted for,
        vii. On 5 May 2021, the medicines record chart for Co-drydramol 10/500mg showed 98 tablets in stock, when 100 tablets were in stock.

These charges are found proved.

The panel considered charges 4. a. vi. and 4. a. vii. together as they related to the same evidence, namely, the evidence of Witness 1 and SUF's Boxed Medicines Record chart dated February 2020.

The panel noted Witness 1's CQC witness statement:

> '*I examined SUF's boxed medicines record chart dated February 2020 and saw that on 4 February 2020, 145 x Co-dydramol 10mg/500mg tablets were in stock. It recorded that two tablets were given on 16 February 2020 and the balance was recorded as 143 tablets. The next and final entry showed that another two tablets were administered on 2 September 2020 and the stock count was recorded as 98 tablets, indicating an unaccounted loss of 45 tablets. On 5 May 2021, I found a box containing 100 Co-dydramol 10mg/500mg tablets in the stock cupboard which had been dispensed on 25 November 2019. This was two more tablets than had been recorded as being in stock in September 2020. The records I examined were confusing and did not show how the Co-dydramol tablets were accounted for.'*

The panel had regard to SUF's Boxed Medicines Record chart and noted that there was no explanation for the 45 Co-dydramol 10/500mg tablets which were unaccounted for, given the discrepancies in the stock count. Further, the panel noted that despite 100 Co-dydramol 10mg/500mg tablets being in the stock and dispensed on 25 November 2019, 98 tablets had been recorded as being in stock on 5 May 2021. The panel considered that this was consistent with the evidence of Witness 1 and it accepted her evidence in respect of these charges.

Accordingly, the panel determined that both of these charges are found proved on a balance of probabilities.

Charge 4. b.

4. In respect of Service User F, failed to ensure that:
    b. The patient was administered prescribed doses of Furosemide 40mg or said medication was signed for as administered on the patient's MAR on 10 and/or 11 December 2021.

This charge is found NOT proved.

The panel noted that it had not been provided with the MAR chart in respect of SUF that included Furosemide 40mg which was the underlying evidence to support Witness 1's CQC statement in relation to this charge. In the absence of this evidence, the panel was not satisfied that this charge had been proved on the balance of probabilities.

Accordingly, the panel determined that this charge is found not proved.

Charge 4. c.

4. In respect of Service User F, failed to ensure that:
    c. In May 2021 and/or December 2021, the patient had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC witness statement that states:

> *'I examined the MARS sheets and Meds Profiles for nine service users and saw that allergy status section was not completed for six service users (SUA, SUP, SUD, SUG, SUF, SUH). It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to.'*

The panel also took into account the exhibited MAR charts and Meds Profiles for SUF, noting that on all of these records the allergy section was incomplete. The panel determined that Witness 1's written evidence was consistent with her oral evidence. The panel accepted the evidence of Witness 1, and it was of the view that SUF had been put at risk in the absence of this important information. The panel was therefore satisfied

that Ms Lea, in respect of SUF, had failed to ensure in May 2021 that SUF had an up-to-date allergy status in their notes.

Accordingly, the panel determined that this charge is found proved.

Charge 5. a. i. and ii.

5. In respect of Service User G, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        i. The medication profile showed that no Co-codamol 8/500mg had been sent, received, or brought forward, when 93 tablets were dispensed on 27 November 2020 and/or 100 tablets were dispensed on 24 December 2020,
        ii. The medication profile showed that no Co-codamol 15/500mg had been sent, received, or brought forward, when 72 tablets were dispensed on 11 May 2020.

Charge 5. a. i. is found proved and charge 5. a. ii. is found NOT proved.

The panel considered charges 5. a. i. and 5. a. ii. together as they related to the same evidence, namely, the evidence of Witness 1 and Service User G's ('SUG') Med Profile dated 26 April 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'On 5 May 2021, I examined SUG's Med Profile Sheet dated 26 April 2021, and saw that no Co-codamol 8/500mg or Co-codamol 15mg/500mg tablets had been recorded as sent, received or brought forward from the previous cycle. I saw that there was a box containing 93 Co-codamol 8/500mg tablets dated as dispensed on 27 November 2020 and an unopened box containing 100 tablets dated as dispensed 24 December 2021, in the stock cupboard both labelled as belonging to SUG. I also found a box of 72 Co-codamol 15mg/500mg tablets plus a loose*

tablet at the bottom of the box in the stock cupboard dated as dispensed 11 May 2020 which was also labelled as belonging to SUG.'

The panel had regard to SUG's Med Profile and noted that there was no record of Co-codamol 8/500mg as being sent, received or brought forward for 26 April 2021. The panel also had sight of a photograph displaying two boxes of Co-codamol 8/500mg dated as dispensed on 27 November 2020 and 24 December 2021 and the remaining medication in the boxes. The panel accepted the evidence of Witness 1, as it was consistent with the documentary evidence before it. The panel concluded that there was Co-codamol 8/500mg in stock for SUG at the Home and therefore, SUG's Med Profile was not accurate record in this regard.

Therefore, the panel determined that charge 5. a. i. is found proved.

The panel then considered charge 5. a. ii in respect of Co-codamol 15/500mg. Whilst the panel acknowledged that it did have a photograph of the remaining medication found by Witness 1 as exhibited in her witness statement, it noted that the medication had not been listed on SUG's Med Profile sheet. In the absence of this information on the Med Profile, the panel was unable to find this charge proved.

Therefore, the panel determined that charge 5. a. ii. is found not proved.

Charge 5. a. iii.

5. In respect of Service User G, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        iii. The medication profile showed that no Macrogol sachets had been sent, received, or brought forward, when 2 sachets were in stock on 5 May 2021.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUG's Med Profile sheet dated 26 April 2021, showing Macrogol compound oral powder sachets.

The panel noted Witness 1's CQC witness statement:

> *'I examined SUG's Med Profile Sheet, dated 26 April 2021, for Macrogol Sachets and none were recorded as sent, received or brought forward from a previous cycle. I saw that two sachets of Macrogol were in stock on the day of the inspection labelled as belonging to SUG. Again, demonstrating the inaccuracy of the records in place and the failure to account for medicine.'*

The panel also had regard to SUG's Med Profile sheet and noted that was no record of Macrogol compound oral powder sachets as being sent, received or brought forward for 26 April 2021. The panel was not provided with a photograph of the two sachets of Macrogol that were in stock on the day of the inspection labelled as belonging to SUG. However, the panel did have sight of the SUG's Med Profile and in the absence of any further evidence to undermine Witness 1's findings, the panel was of the view that Witness 1 had found two sachets of Macrogol in stock at the Home and therefore, SUF's Med Profile was not an accurate record.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 5. a. iv.

5. In respect of Service User G, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        iv. No Enzalutamide 40mg was recorded as being in stock, when 2 labelled boxes and/or 1 unlabelled box were dispensed on 8 April 2021.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC witness statement:

> *'On 5 May 2021, I examined SUG's MAR chart dated 1 May 2021 and saw they were prescribed Enzalutamide 40mg tablets, oral chemotherapy, four tablets to be taken daily. I found no quantity of this medication recorded on the chart. I found two boxes of the tablets, dispensed on 8 April 2021, labelled as belonging to SUG in the stock cupboard and an un-labelled pack in the trolley. There was no record of any of these tablets being in stock in the home. This meant it was not possible to tell if the chemotherapy tablets had been administered as prescribed not [sic] could this medicine be accounted for […]'*

The panel noted that this medication was not listed on SUG's Med Profile sheet, however, it had sight of a photograph taken of Enzalutamide 40mg tablets boxes showing that it was prescribed for SUG, dispensed on 8 April 2021. It also had sight of a photograph showing an unlabelled pack of this medication. The panel noted that this was consistent with the evidence of Witness 1, in that there was '*no quantity of this medication recorded on the chart'* and that '*There was no record of any of these tablets being in stock in the home'.*

Accordingly, the panel determined that this charge is found proved.

Charge 5. a. v.

5. In respect of Service User G, failed to ensure that:
    a. Accurate records of medication were kept, in that:
    v. 5 Midazolam 5mg/ml injections were received on 29 September 2021, In December 2021 only 3 were in stock, but none were recorded as administered to the patient.

This charge is found proved.

In reaching this decision the panel took into account the evidence of Witness 1 and SUG's Controlled Drug ('CD') book.

The panel noted Witness 1's CQC witness statement states:

> *'In December 2020 I saw that SUG was prescribed Midazolam 5mg/ml injections, usually prescribed for agitation and terminal restlessness. Midazolam is a schedule 3 controlled drug but does not need to be stored in a CD cupboard or records made in a CD register. Common practice suggests that these injections are recorded in the CD register because they are drugs of potential abuse. I examined the controlled drug register and page 9 showed that on 29 September 2021 five Midazolam 5mg/ml injections were recorded as received, none had been signed as given but only three ampoules were in stock, indicating that two were unaccounted for.'*

The panel had regard to the CD book and noted that there was no record for the administration of Midazolam 5mg/ml injections and the balance showed five injections in stock. The panel also had sight of a photograph exhibited by Witness 1 which showed only three Midazolam 5mg/ml injections. The panel accepted the evidence of Witness 1, as it was consistent with the documentary evidence before it. Therefore, the panel concluded that there were only three Midazolam 5mg/ml injections in stock at the Home and it was recorded there were five. Therefore, the CD book was not an accurate record.

Accordingly, the panel determined that this charge is found proved.

Charge 5. b. i.

5. In respect of Service User G, failed to ensure that:
    b. The patient's medication was administered safely, in that:
        i. On 2 May 2021, Alendronic Acid and Dexamethasone were administered together when Alendronic Acid should be administered 30

minutes before food, drink, and any other medication, and Dexamethasone should be administered with or after food.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUG's Med Profile.

The panel had regard to SUG's Med Profile and noted that it contained the following instructions for the administration of each of the drugs stated in the charge:

> *'**Alendronic acid 70mg tablets***
> *Take ONE Tablet a week on Sunday […]*
> *Take 30 minutes before the first food, drink or medication of the day […]'*
>
> *'**Dexamethasone** […]*
> *ONE to be taken DAILY*
> *Taken before or after food. Please read additional*
> *Information given with this medicine'*

The panel noted Witness 1's CQC witness statement states:

> *'I saw that SUG was prescribed Alendronic Acid 70mg tablets (for bone strength) once a week. The Med Profile dated 26 April 2021, stated this medicine must be "taken 30 minutes before first food, drink or medication of the day with a full glass of water. Do not lie down for 30 minutes after taking this". The Med Profile shows they were also prescribed Dexamethasone 500mcg tablets (used to treat a wide variety of inflammatory conditions); one to be taken daily "take with or after food". The MAR Chart dated 26 April 2021 shows that both these medicines were signed as given together on 2 May 2021. It is not possible to safely administer both these medicines together as they both have different directions with regard to food. Neither medicine may work effectively if they are not administered in line*

with the manufacturers' directions placing SUG's health at risk. Appendix 42 shows SUG's MAR Chart dated 26 April 2021'.

The panel did not have sight of SUG's MAR chart (Appendix 42 as referenced in Witness 1's statement) which would have evidenced when these tablets were administered. Therefore, in the absence of this information, the panel was unable to conclude that SUG's Alendronic Acid and Dexamethasone were administered together.

Accordingly, the panel determined that this charge is found not proved.

Charge 5. b. ii.

5. In respect of Service User G, failed to ensure that:
    b. The patient's medication was administered safely, in that:
        ii. A Midazolam 5mg/ml injection prescribed to Service User G was administered to Service User T.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the photograph of the local investigation paperwork regarding SUG's Midazolam.

The panel noted that Witness 1's CQC witness statement states:

'on our second day of inspection Karen Lea and staff member M explained that their records showed that one of the missing ampoules had been given to SUG from SUT's stock on 6 December 2021 by Staff member T and Staff member D. They were unable to account for the second missing ampoule and they failed to send the commission any information after the inspection despite the fact the manager told us the investigation was on going.'

The panel also had regard to the investigation paperwork, which show that one of the vials of Midazolam 5mg/ml for SUG was administered to SUT. The panel also noted that

Ms Lea had told Witness 1 that '*one of the missing ampoules had been given to SUG from SUT's stock on 6 December 2021 by Staff member T and Staff member D'* and that Ms Lea made no comment about this charge or contested it in her written submissions. Therefore, the panel concluded that Ms Lea failed to ensure that SUG's medication was administered safely, in that a Midazolam 5mg/ml injection prescribed to SUG was administered to SUT.

Accordingly, the panel determined that this charge is found proved.

Charge 5. c. i. and ii.

5. In respect of Service User G, failed to ensure that:
    c. PRN protocols were adequate, in that:
        i. The patient was prescribed Metoclopramide 10mg, but there was no PRN protocol in place,
        ii. The patient was prescribed Co-codamol 8/500mg, but there was no PRN protocol in place.

These charges are found proved.

The panel considered charges 5. c. i. and 5. c. ii. together as they related to the same evidence, namely, the evidence of Witness 1 and SUG's Med Profiles showing Metoclopramide 10mg and Co-codamol 8/500mg.

The panel noted that Witness 1's CQC witness statement states:

> *'SUG was prescribed Metoclopramide 10mg tablets and Co-Codamol 8/500mg tablets both were prescribed to be taken when required. I saw there were no protocols in place on the day of the inspection.'*

The panel noted that SUG had PRN charts for both Metoclopramide 10mg and Co-codamol 8/500mg. However, the panel did not have sight of a PRN protocol for either

medication. In the absence of these protocols, the panel determined that these charges are found proved.

Charge 5. d.

5. In respect of Service User G, failed to ensure that:
    d. In May 2021, the patient had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC statement that states:

> *'I examined the MARS sheets and Meds Profiles for nine service users and saw that allergy status section was not completed for six service users (SUA, SUP, SUD, SUG, SUF, SUH). It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to*.

The panel noted that Witness 1's evidence was also consistent with her oral evidence. The panel had regard to all of the MAR charts and Med Profiles in respect of SUG and noted that there was nothing recorded in the allergies or notes section. In the absence of any further documentation to undermine this, the panel concluded that Ms Lea failed to ensure in May 2021 that SUG had an up-to-date allergy status recorded in their notes.

Accordingly, the panel determined that this charge is found proved.

Charge 6. a. i.

6. In respect of Service User H, failed to ensure that:

a. Accurate records of medication administration were kept, in that, on 29 April 2021:
    i. No lunchtime dose of Docusate 100mg was administered or signed for.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and Service User H's ('SUH') MAR chart dated 26 April 2021.

The panel noted Witness 1's CQC statement that states:

> *'I examined the MAR dated 26 April 2021 for SUH and saw a gap where nurses had failed to sign to show they had administered the lunchtime dose, 29 April 2021, of Docusate 100mg capsules (usually prescribed for constipation), prescribed to be taken three times daily. I also examined the notes chart for SUH and saw that no notes had been made to explain the gap. Appendix 33 shows SUH's MARs dated 26 April 2021'.*

The panel noted that no signature was recorded to show that Docusate 100mg was administered on 29 April 2021 at lunchtime, and that no notes had been recorded to explain why the medication had not been administered. However, although the panel found that there were errors in the recording of medication administration on 29 April 2021, it considered that Ms Lea could not be expected to have that level of oversight over such a short period of time. The panel concluded that the registered nurses at the Home were responsible for their own clinical practice and it was reasonable for Ms Lea to expect them to accurately record medication administration without the need for daily monitoring.

Accordingly, the panel determined that this charge is found not proved.

Charge 6. a. ii.

6. In respect of Service User H, failed to ensure that:
    a. Accurate records of medication administration were kept, in that, on 29 April 2021:
        ii. No lunchtime and/or teatime dose Co-codamol 8/500mg was administered or signed for.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUH's MAR chart dated 26 April 2021.

The panel noted Witness 1's CQC statement that states:

> *'I examined SUH's Interim Chart dated 27 April 2021, which showed they were prescribed Co-Codamol 8/500mg effervescent tablets (usually prescribed for pain relief), one to be taken four times a day. There were gaps on 29 April 2021 at lunch and tea-time, so it was not possible to tell if they were offered or given their pain relief as prescribed. I also examined the notes chart and saw that no notes had been made to explain the gaps […]'*

The panel noted that no signatures were recorded to show that Co-codamol 8/500mg was administered on 29 April 2021 at lunchtime and teatime and that no notes had been recorded to explain why the medication had not been administered. However, although the panel found that there were errors in the recording of medication administration on 29 April 2021, it considered that Ms Lea could not be expected to have that level of oversight over such a short period of time. The panel concluded that the registered nurses at the Home were responsible for their own clinical practice and it was reasonable for Ms Lea to expect them to accurately record medication administration without the need for daily monitoring.

Accordingly, the panel determined that this charge is found not proved.

Charge 6. a. iii.

6. In respect of Service User H, failed to ensure that:
    a. Accurate records of medication administration were kept, in that, on 29 April 2021:
        iii. No explanation was recorded for the omissions at charges 6.b.i and/or 6.b.ii.

This charge is found NOT proved.

In reaching this decision the panel took into account SUH's MAR chart dated 26 April 2021 and noted that no explanations were recorded to explain the omissions. However, although the panel found that there were errors in the recording of medication administration on 29 April 2021, it considered that Ms Lea could not be expected to have that level of oversight over such a short period of time. The panel concluded that the registered nurses at the Home were responsible for their own clinical practice and it was reasonable for Ms Lea to expect them to accurately record medication administration without the need for daily monitoring.

Accordingly, the panel found this charge is not proved.

Charge 6. b.

6. In respect of Service User H, failed to ensure that:
    b. A PRN protocol was in place for Lorazepam 1mg.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUH's PRN chart dated 26 April 2021.

The panel noted Witness 1's CQC statement that states:

'SUH's PRN MARS dated 26 April 2021 showed they were prescribed Lorazepam 1 mg tablets; half to be taken once daily when required. There was no protocol in place on the day of the inspection.'

The panel noted that SUH had a PRN chart for Lorazepam 1mg. However, the panel was not provided with a PRN protocol for this medication. In the absence of this protocol, the panel determined that this charge is found proved.

Charge 6.c.

6. In respect of Service User H, failed to ensure that:
    c. In May 2021, the patient had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC witness statement that states:

'I examined the MARS sheets and Meds Profiles for nine service users and saw that allergy status section was not completed for six service users (SUA, SUP, SUD, SUG, SUF, SUH). It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to.'

The panel also took into account the exhibited MAR charts and Med Profiles for SUH, noting that on all of these records the allergy section was incomplete. The panel determined that Witness 1's written evidence was consistent with her oral evidence. The panel accepted the evidence of Witness 1, and it was of the view that SUH had been put at risk in the absence of this important information. The panel was therefore satisfied that Ms Lea had failed to ensure in May 2021 that SUH had an up-to-date allergy status in their notes.

Accordingly, the panel determined that this charge is found proved.

Charge 7.a.i.

7. In respect of Service User I, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        i. In April 2021, different symbols were used on the patient's MAR chart for olive oil ear drops without explanation.

This charge is found NOT proved.

The panel noted Witness 1's CQC witness statement that states:

> *'SUI's PRN chart, dated 29 March 2021, listed Olive Oil ear drops to be used as directed. I saw that the drops had only been signed as administered once on 2 April 2021, on 3 April 2021 the ' ✓' symbol was on the MAR instead of a signature and the symbol "X" was used on 8, 10, 16 and 17 April 2021. There was no explanation as to the meaning of these symbols, so it is unclear if SUI had their ear drops instilled on those days.'*

The panel had sight of Service User I's ('SUI') PRN chart dated 29 March 2021 and noted that this was supported by the Witness 1's statement, in that the drops had only been signed as administered once on 2 April 2021. On 3 April 2021 a ' ✓' symbol was on the PRN chart instead of a signature and the symbol "X" was used on 8, 10, 16 and 17 April 2021. No explanation was given to explain the meaning of the different symbols.

However, although the panel found that there were anomalies in the recording of medication administration in April 2021, it considered that Ms Lea could not be expected to have that level of oversight over this period of time for a PRN medication. The panel concluded that the registered nurses at the Home were responsible for their own clinical

practice and it was reasonable for Ms Lea to expect them to accurately record medication administration without the need for daily monitoring.

Accordingly, the panel determined that this charge is found not proved.

Charge 7.a.ii.

7. In respect of Service User I, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        ii. On 5 May 2021, olive oil ear drops were not administered or not recorded as administered on the patient's MAR chart.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC witness statement that states:

> *'On 5 May 2021, I examined the MARs in current use for SUI and found there was no entry for Olive Oil Ear drops. I asked Staff member S if the drops I had found on the top of the trolley were in use and they confirmed that they were in use for and they had administered them to SUI but had not made any records of doing so.'*

However, the panel had not been provided with a MAR chart that Witness 1 refers to in her statement relating to 5 May 2021 but rather a chart relating to 29 March 2021.
In the absence of the relevant document, the panel could not be satisfied on a balance of probabilities that olive oil ear drops were not administered or not recorded as administered on the SUI's MAR chart.

Accordingly, the panel determined that this charge is found not proved.

Charge 7. a. iii.

7. In respect of Service User I, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        iii. Between 26 April and 4 May 2021, Senna 7.5mg was administered PRN, 2 tablets on 26 April 2021, 1 tablet every other day, with no rationale recorded as to why different doses were required.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUI's PRN chart dated 26 April 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'SUI was prescribed Senna 7 .5mg one or two tablets to be taken at night when required. I saw there was no protocol in place on the day of the inspection. I saw that SUI was given Senna each day between 26 April and 4 May 2021. On 26 April 2021 two tablets were administered and on all other nights only one tablet was administered. I found there were no records explaining the rationale for giving different doses.'*

The panel noted that Senna 7.5mg had been prescribed as a PRN medication and that the administration instructions on the PRN chart state:

> '*ONE or TWO to be taken at NIGHT WHEN REQUIRED […]*'

The panel was of the view that as this was a PRN medication, there was not a requirement to record why different doses were administered. Therefore, the panel determined that this charge is found not proved.

Charge 7. b. i.

7. In respect of Service User I, failed to ensure that:

b. The patient's medication was administered safely, in that:
    i. In April 2021, olive oil ear drops were not administered twice daily.

This charge is found proved.

In reaching this decision, the panel took into account SUI's PRN chart dated 29 March 2021 relating to olive oil ear drops.

The panel noted Witness 1's CQC witness statement that states:

> *'[…] I noted this pattern of administration did not follow the guidelines published by NICE (National Institute of Clinical Excellence) for the use of Olive Oil Ear drops, which should be followed in the absence of any other directions by the prescriber. The guidelines state the drops should be used twice daily for several days to soften the wax. This guidance shows that SUI had their ear drops did not have their ear drops instilled safely [sic] and would unlikely to be effective in softening the wax which would be uncomfortable or painful and their hearing would remain diminished.'*

The panel had regard to SUI's PRN chart and noted that the olive oil drops had not been administered twice a day. On the PRN it also states: '*see leaflet for storage and administration instructions'.* The panel was provided with a photograph of the olive oil ear drops for SUI showing the manufacturer's directions. This states:

> *'use the drops twice a day up to seven days'*

The panel concluded that the olive oil ear drops had not been administered in accordance with the manufacturer's directions, namely, twice a day and accordingly, the panel determined that this charge is found proved.

Charge 7. b. ii.

7. In respect of Service User I, failed to ensure that:

b. The patient's medication was administered safely, in that:

ii. Olive oil ear drops, dispensed on 11 February 2021, were used after 28 days of opening.

This charge is found NOT proved.

In reaching this decision the panel took into account the evidence of Witness 1, SUI's PRN chart dated 29 March 2021 and a photograph of olive oil ear drops for SUI.

The panel noted Witness 1's CQC witness statement that states:

> *'On 5 May 2021, I examined the MARs in current use for SUI and found there was no entry for Olive Oil Ear drops. I asked Staff member S if the drops I had found on the top of the trolley were in use and they confirmed that they were in use for and they had administered them to SUI but had not made any records of doing so.[…]'*
>
> *There was no opening date on the ear drops which had been dispensed on 11 February 2021, which was more than 28 days previous. If the drops had first been used on 2 April 2021, that was over 28 days. The drops were in use on the 5 May 2021 and were out of date, which placed SUI at risk of an ear infection.'*

The panel noted that although the PRN chart is dated 29 March 2021, the chart was not signed as administered until 2 April 2021. Further, the panel noted that it did not have sight of SUI's PRN chart including 5 May 2021 to confirm they were in use at that time. In these circumstances, panel were unable to conclude that SUI's olive oil ear drops were used after 28 days of opening.

Accordingly, the panel determined that this charge is found not proved.

Charge 7. b. iii.

7. In respect of Service User I, failed to ensure that:

b. The patient's medication was administered safely, in that:

iii. On 3 May 2021, Alendronic Acid was administered together with other medicines when it should be administered 30 minutes before food, drink, and other medication.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUI's MAR chart showing Alendronic Acid and other medications to be taken in the morning, dated 26 April 2021 and SUI's Meds Profile Chart dated 26 April 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'I saw that SUI was prescribed Alendronic Acid 70mg tablets (for bone strength); one to be taken on the same day each week. The Med Profile dated 26 April 2021, stated that it must be " taken 30 minutes before first food, drink or medication of the day with a full glass of water.[…] The MAR Chart dated 26 April 2021 showed that this medicine was signed as given together on 3 May 2021, with five other medicines that morning despite the directions stating it must be given 30 minutes before any other medicines. The Alendronic Acid tablets may not work effectively to improve bone strength if they are not administered in line with the manufacturers' directions'*

The panel had regard to SUI's MAR chart and noted that was nothing recorded on the chart to suggest that this medication was given before the other medications on 3 May 2021.The panel accepted the evidence of Witness 1 as it was consistent with the documentary evidence before it. Therefore, the panel concluded that Ms Lea had failed to ensure that SUI's Alendronic Acid was administered safely on 3 May 2021.

Accordingly, the panel determined that this charge is found proved.

Charge 7. b. iv.

7. In respect of Service User I, failed to ensure that:
    b. The patient's medication was administered safely, in that:
        iv. Between 26 April and 4 May 2021, Mebeverine was administered at teatime, when it should be administered 20 minutes before food.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUI's MAR chart dated 26 April 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'SUI's Med Profile also showed they were prescribed Meberverine 200mg modified release capsules one to be taken twice daily, "take 20 minutes before meals" (an antispasmodic to ease painful stomach cramps). I saw no evidence that this medicine was given before food and the MAR Chart shows that it was administered at "teatime" daily between 26 April and 4 May 2021. This means the antispasmodic may not work effectively and SUI may suffer unnecessarily with stomach cramps.'*

The panel was not provided with SUI's Med Profile showing Meberverine 200mg. However, it was provided with SUI's MAR chart dated 26 April 2021, which listed this medication to be given at 'TEA'. In the absence of any further evidence to undermine Witness 1's findings, the panel accepted the evidence of Witness 1 and concluded that SUI's Mebeverine was not administered safely between 26 April and 4 May 2021.

Accordingly, the panel determined that this charge is found proved.

Charge 7. c. i.

7. In respect of Service User I, failed to ensure that:
    c. PRN protocols were adequate, in that:

i. The patient was prescribed Senna 7.5mg, but there was no PRN protocol in place.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUI's PRN chart dated 26 April 2021.

The panel noted that Witness 1's CQC witness statement states:

> *'SUI was prescribed Senna 7.5mg one or two tablets to be taken at night when required. I saw there was no protocol in place on the day of the inspection.*'

The panel noted that SUG had a PRN chart for Senna 7.5mg. However, the panel was not provided with a PRN protocol for this medication. In the absence of this protocol, the panel determined that this charge is found proved.

Charge 7. c. ii.

7. In respect of Service User I, failed to ensure that:
    c. PRN protocols were adequate, in that:
        ii. The patient was prescribed Cosmocol sachets, up to 3 doses per day, but there was no information in the PRN protocol on how to assess the appropriate dose.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUI's PRN protocol for Cosmcol.

The panel noted that Witness 1's CQC witness statement states:

'SUI was prescribed Cosmocol sachets once to be taken each day, can be increased to up to three sachets as day as required. The PRN protocol in place failed to give any information as to how the need for the medicine would be assessed. There was no information recorded how to assess the need in order to increase the dose to two or three sachets daily.'

The panel had regard to SUI's PRN protocol for Cosmcol and whilst it considered the protocol lacked detail, it was adequate.

Accordingly, the panel determined that this charge is found not proved.

Charge 7. c. iii.

7. In respect of Service User I, failed to ensure that:
    c. PRN protocols were adequate, in that:
        iii. The patient was prescribed Paracetamol 500mg, 2 tablets up to 4 times daily, and Codeine 15mg, 1 or 2 tablets up to 4 times daily, but there was no information in the PRN protocol on how to assess which medication should be used first and/or how to assess the correct dose of Codeine.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUI's PRN protocol for Paracetamol and Codeine.

The panel noted that Witness 1's CQC witness statement states:

'SUI was prescribed Paracetamol 500mg tablets; two to be taken up to four times daily and Codeine 15mg tablets; one or two to be taken up to four times daily, both prescribed for pain. The PRN protocols in place failed to give any information as to how the need for each medicine would be assessed or which analgesic should be used as first line pain relief. There was no information

recorded how to select the most appropriate dose of Codeine. […] I examined the notes chart, dated 26 April 2021, associated with the administration of Paracetamol for SUI and found it failed to record the result or the effectiveness of the dose of pain relief.'

The panel also noted the PRN protocols did not refer to each other which is important as they are both pain relief medications and that the information provided on both charts was inadequate, in that there is no information on how to assess which medication should be used first and/or how to assess the correct dose of Codeine.

The panel accepted the evidence of Witness 1 as it was consistent with its findings.

Accordingly, the panel determined that this charge is found proved.

Charge 8. a. i.

8. In respect of Service User J, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        i. The medication profile showed that no Lantus Solostar 100unit/ml insulin pens were in stock, when 6 were in the fridge labelled for the patient.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness1 and Service User J's ('SUJ') medicine's profile dated 26 April 2021.

The panel viewed SUJ's Med Profile exhibited by Witness 1, but the Lantus Solostar insulin pens were not listed on that document. In addition, the panel was shown pictorial evidence of 6 Lantus Solostar pens stored in a fridge. However, it was not clear whether these were the pens prescribed specifically for SUJ as no medication labels were visible.

Therefore, the panel could not be satisfied that the Lantus Solostar 100unit/ml insulin pens belonged to SUJ nor could they be satisfied the insulin pens were prescribed to SUJ as they were not listed on their Meds profile.

Accordingly, the panel determined that this charge is found not proved on a balance of probabilities.

Charge 8. a. ii.

8. In respect of Service User J, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        ii. The medication profile showed that a Contour XT blood sugar testing machine and/or testing strips were not in stock when they were.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's written CQC statement dated 30 March 2022, a photograph of SUJ's pouch and blood sugar testing machine, a photograph of SUJ's Medication Profile showing Control Next Strips dated 26 April 2021, and a photograph of SUJ's Nexus Strips dated January 2021.

The panel noted Witness 1's CQC statement:

> *'… I saw that there was a blood sugar testing machine in a pouch with the shortened version of **SUJ**'s name first taped on the pouch. **Staff member S** confirmed it belonged to **SUJ**. The machine in the pouch was a Contour XT and the test strips to be used in this machine are called Contour NEXT test strips…'*

The panel also noted that SUJ's Medication Profile dated 26 April 2021 did not show the Contour XT. and it was recorded for the Next testing strips that there were none sent, received or brought forward. However, the panel had regard to a photograph showing the Nexus Strips were in stock and were labelled as belonging to SUJ.

Accordingly, the panel determined that the records were inaccurate in that both the blood sugar machine and testing strips were in stock when they were recorded as not being in stock. Therefore, this charge is found proved.

Charge 8. a. iii.

8. In respect of Service User J, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        iii. Fridge temperatures were not recorded daily.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the fridge temperature records sheet.

The panel noted Witness 1's CQC statement:

> *'I examined the fridge temperature records and saw they were not always completed daily and the date was not always accurately recorded.'*

The panel noted that, having regard to the records of the fridge temperature between 26 February - 5 May 2021, there was no record made on 30 April 2021 and there were no records between 2 April and 4 May 2021.

Accordingly, the panel determined that this charge is found proved.

Charge 8. b. i.

8. In respect of Service User J, failed to ensure that:
    b. The patient's medication was administered safely, in that:

i. A Nexus GlucoRx blood sugar testing machine was used when the test strips and/or the solution to calibrate the machine was out of date.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and a photograph of SUJ Nexus Strips dated January 2021.

The panel noted Witness 1's CQC statement:

> *'… **Staff member S** told me that they used a different blood glucose monitoring machine (Nexus Gluco Rx) and confirmed it was not prescribed for **SUJ** but they used it because it was in better condition. I saw that the Nexus test strips in the pouch with the machine were out of date and had gone out of date in January 2021. If the strips are not in date, they may not reliably give accurate blood sugar readings. I also saw the control solution used to calibrate the machine was also out of date and it had gone out of date on 23 April 2021. I asked **Staff member S** when the machine had last been calibrated and they said they had "no idea" and confirmed there was no records of the machine being calibrated…'*

The panel had sight of the photograph of SUJ's Nexus Strips and saw that the strips and the solution used to calibrate the testing machine were out of date.

Accordingly, the panel determined that this charge is found proved.

Charge 8. c. i.

8. In respect of Service User J, failed to ensure that:
    c. Medication was stored safely, in that:
        i. The fridge temperature fell to -24°C, when the minimum appropriate temperature was 0°C.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and a photograph of the thermometer in the fridge showing minus 24 and frost.

The panel noted Witness 1's CQC statement:

> *'… I looked inside the fridge which contained the insulin and saw that the fridge needed defrosting due to a build-up of ice. I also found at 11:43am, that the fridge thermometer, inside the fridge showed the minimum temperature registered was minus 24C, indicating the contents of the fridge would have been frozen. The minimum or maximum temperature displayed remains as that temperature until the thermometer is reset. At 11:55am the display on the fridge thermometer was blank. At 15:56 the display on the fridge thermometer was 0C min, 2C max and 1C actual temperature. I questioned whether it was working properly, and the* ***Staff member S*** *told me it was…'*

Witness 1 also stated:

> *'The manufacturers advise that insulin must be stored between 2 and 8C and must not be frozen. If insulin is frozen, it must not be used even if it has thawed out, because freezing will break down the insulin so it will not be effective in controlling blood sugar levels'.*

The panel noted from the photograph that although the current temperature was recorded at three degrees the fridge had at some point reached minus 24 degrees. Given that the manufacturer advises insulin should be stored between two and eight degrees, the panel concluded the medication was not stored safely.

Accordingly, the panel determined that this charge is found proved.

Charge 8. c. ii.

8. In respect of Service User J, failed to ensure that:
    c. Medication was stored safely, in that:
        ii. Lantus Solostar 100unit/ml insulin pens were kept in the fridge, when they should be stored between 2 and 8°C.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1, a photograph of the Lantus Solostar 100 unit/ml insulin pens in the fridge and the guidance on storing this medication.

Although the panel saw evidence of the insulin pens being stored in the fridge, the panel could not establish that the insulin pens were prescribed for SUJ.

Accordingly, the panel determined that this charge is found not proved on a balance of probabilities.

Charge 8. d.

8. In respect of Service User J, failed to ensure that:
    d. The PRN protocol for Glucogel had information as to how the need for the medicine would be assessed.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUJ's PRN protocol for Glucogel.

The panel noted that the reason for administration on the PRN protocol states;

'to be used in case of hypoglycaemia as per first aid'.

Witness 1 in her oral evidence explained to the panel that hypoglycaemia can present differently from person to person and a baseline blood sugar range for SUJ should have been provided in the protocol to determine when Glucogel was required. The panel accepted the evidence of Witness 1 and found the guidance lacked sufficient detail required.

Accordingly, the panel determined that this charge is found proved.

Charge 9.

9. In respect of Service User K, failed to ensure the patient's Nexus blood sugar testing strips were in date.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and a photograph of Service User K's ('SUK') Nexus Strips.

Witness 1's CQC statement states:

> *'Together with staff member S I found there were three other boxes of Nexus test strips dispensed for SUK during 2020. We saw that two out of the three containers of test strips were out of date… If test strips and control solutions are out of date and the machine had not been calibrated, the blood sugar readings may not be reliable or accurate which placed the service-user's health at risk of harm.'*

The panel also noted that the photograph of SUK's Nexus blood sugar testing strips show as being out of date, corroborating Witness 1's statement.

Accordingly, the panel determined that this charge is found proved.

Charge 10.a.i.

10. In respect of Service User M, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        i. On 6 December 2021, the medication profile showed that there was no Tranexamic acid 500mg tablets in stock when at least 54 tablets were in stock.

This charge is found proved.

In considering this charge the panel had regard to Witness 1's statement which states:

> *'On 16 December 2021, I saw that **SUM** was prescribed Tranexamic acid tablets two to be taken three times daily when required to reduce vaginal bleeding. examined **SUM's** Med Profile dated 11 October 2021 saw that 54 tablets Tranexamic Acid 500mg tablets had been "brought forward" from the previous cycle…Their Med Profile dated 8 November 2021 recorded that 54 tablets Tranexamic Acid 500mg tablets had been "brought forward" from the previous cycle… I then examined an interim PRN MAR chart dated 24 November 2021 and saw that 120 tablets had been received and 54 tablets had been recorded as brought forward and the total number of tablets in stock was 174. ... I then examined the Med Profile dated 6 December 2021 and saw none were recorded as received or brought forward and the stock level was recorded as zero... On 16 December I found a box containing 54 tablets of Tranexamic Acid 500mg tablets, two tablets to be taken three times daily when required, which had been dispensed for **SUM** on 9 April 2021 and opened on 4 October 2021. Records about the stocks of medicines should provide a clear audit trail to show how much stock is in the home and how much medicine has been administered…'*

The panel also had sight of the Med Profiles dated 11 October 2021, 8 November 2021, Interim PRN chart dated 24 November 2021, and the Med Profile dated 6 December 2021. It noted that 54 Tranexamic acid tablets 500mg were brought forward on 11 October 2021 and this was recorded on the PRN chart on 24 November 2021 but there

was no record of any of the tablets being sent, received or brought forward on the chart of 6 December 2021 suggesting no tablets were in stock at the Home. The panel accepted Witness 1's evidence that she found a box containing 54 tablets prescribed for Service User M ('SUM') on 16 December 2021. The panel concluded that the Med Profile chart of 6 December 2021 was inaccurate and therefore found this charge proved.

Charge 10.a.ii

10. In respect of Service User M, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        ii. Between 4 February and 19 July 2020, approximately 27 Paracetamol 500mg tablets went unaccounted for.

This charge is found proved.

In considering this charge, the panel had regard to the Witness 1's statement which states:

> *'On 16 December 2021, I examined **SUM's** records about Paracetamol 500mg tablets; two to be taken up to four times daily when required . A boxed Medicines Record Chart was in place for Paracetamol…This chart recorded the date, time and quantity given in each dose together with the nurses' signatures and the running total. This chart is intended to show that Paracetamol is accounted for. The chart commenced on 4 February 2020, with a running total balance of 132 tablets and recorded that three doses (six tablets) had been given by 21 June 2020 and the running total was 126 tablets. A stock check was made on 19 July 2020 and only 99 tablets were in stock. There was no information recorded to show how the other 27 tablets were accounted for…'*

The panel also considered the boxed paracetamol chart and the PRN Med Profile. On 21 June 2020 there were 126 500mg paracetamol tablets in stock. The next entry is on

19 July 2020 where 99 tablets were recorded as being in stock, but there was no record of any tablets being given to SUM between those dates.

The panel considered that Ms Lea had overarching responsibility as the registered Home Manager to ensure that accurate records of medication stock were kept. The panel noted that this occurred over a four-month period and would have been identified if there were effective auditing processes in use. The panel concluded that 27 500mg paracetamol tablets had not been accounted for in the box paracetamol chart and determined that the record was inaccurate and therefore found this charge proved.

Charge 10.a.iii

10. In respect of Service User M, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        iii. Between 19 July 2020 and 20 October 2021, approximately 100 Paracetamol 500mg tablets went unaccounted for.

This charge is found proved.

In considering this charge, the panel had regard to the Witness 1's statement, and associated exhibits, which states:

> *'A stock check was made on 19 July 2020 and only 99 tablets were in stock. There was no information recorded to show how the other 27 tablets were accounted for. On 19 July 2020, 100 tablets were recorded as received and the balance was 199, an increase of 100 tablets and no explanation was recorded as to why there were more tablets. Two tablets were recorded as given on 4 August 2020, which meant that the expected running balance was 197 and the running balance was 194 (a discrepancy of three tablets). Six further tablets were recorded as given and the expected balance on 28 January 2021 was as recorded 188 tablets.*

The chart shows that five more doses recorded as were given between 12 March and 24 June 2021 (10 tablets) but no running balance was recorded. A record of a stock check was made on 16 June 2021, but this check was written on the chart after the dose recorded as given on 24 June 2021. The stock check showed there were 200 tablets in stock, despite the fact there was no record of any tablets being received. The next stock check was recorded on 19 July 2021 and again despite no tablets being recorded as given or disposed of the running total was recorded as 100 tablets. Two more entries were made on 19 and 20 October 2021 and the final running total was recorded as 94 tablets.'

The panel cross referenced Witness 1's statement with the boxed medicine record chart for SUM in relation to 500mg paracetamol, and concluded that between 94-100 tablets were not accurately accounted for between 19 July 2020 and 20 October 2021. The panel considered that Ms Lea had overarching responsibility as the registered Home Manager to ensure that accurate records of medication stock were kept. The panel noted that this occurred over an extensive period and would have been identified if there were effective auditing processes in use.

The panel therefore found this charge proved.

Charge 10.a.iv

10. In respect of Service User M, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        iv. On 6 December 2021, the medication profile showed that no Paracetamol 500mg tablets had been received or brought forward, when there were 92 tablets in stock.

This charge is found proved.

In considering this charge, the panel had regard to Witness 1's statement which states:

'I examined the Med Profile dated 6 December 2021 for Paracetamol and saw that no tablets had been recorded as sent, received or brought forward... On 20 December 2021, I found a box of Paracetamol labelled and dispensed on 6 August 2021 for SUM in stock. I counted there were 92 tablets in the box.'

The panel also had regard to SUM's Med Profile and noted that there was no record of any paracetamol being sent, received, brought forward, or totalled on 6 December 2021. The panel accepted Witness 1's evidence that on her visit to the care home on 20 December 2021 she found a box of paracetamol prescribed for SUM that had been dispensed on 6 August 2021, containing 92 500mg tablets. The panel considered that Ms Lea had overarching responsibility as the registered Home Manager to ensure that accurate records of medication stock were kept. Therefore, the panel concluded that the Med Profile of 6 December 2021 for SUM was not accurate and accordingly found this charge proved.

Charge 10.a.v.

10. In respect of Service User M, failed to ensure that:
    a. Accurate records of medication administration were kept, in that:
        v. Between 30 October and 11 November 2021, 4 Amoxycillin 500mg capsules went unaccounted for.

This charge is found proved.

In considering this charge the panel had regard to the evidence of Witness 1 which states:

'Between 30 October and 11 November 2021 nurses signed they had given two capsules [Amoxycillin 500mg] three times a day for 13 days, which was 78 capsules and a dose in the morning 12 November 2021 made the number of capsules administered= 80. This means that 85 (165 - 80) capsules should remain after the dose… however the balance recorded was 81, indicating four capsules were unaccounted for…'

The panel also had regard to the interim chart for Amoxycillin for SUM start date 28 October 2021. Although the panel was not able to determine how the discrepancy occurred, it accepted the evidence of Witness 1 that four 500mg Amoxycillin capsules were unaccounted for between 13 October 2021 and 11 November 2021. The panel considered that Ms Lea had overarching responsibility as the registered Home Manager to ensure that accurate records of medication stock were kept.

The panel therefore found this charge proved.

Charge 10.b.i.

10. In respect of Service User M, failed to ensure that:
    b. The patient's medication was administered safely, in that:
        i. On 13 December 2021, Alendronic acid, Levothyroxine, and other medicines, were administered together, when Alendronic acid should be administered 30 minutes before food, drink, and other medication.

This charge is found NOT proved.

In considering this charge the panel had regard to SUM's MAR chart dated 6 December 2021 and noted that the Alendronic Acid was administered on Sunday 12 December 2021 and not 13 December 2021 as outlined in the charge. The panel was not able to find this charge proved as the evidence did not reflect the date contained in the charge.

Charge 10.b.ii

10. In respect of Service User M, failed to ensure that:
    b. The patient's medication was administered safely, in that:
        ii. Between 6 and 16 December 2021, Levothyroxine was administered with other medication when it should be administered 30-60 minutes before food, drink, and other medication.

This charge is found NOT proved.

In considering this charge, the panel had regard to Witness 1's statement which states:

> *'When I examined the MAR chart for… I also saw **SUM** was also prescribed Levothyroxine 100mcg tablets: one in the morning taken preferably 30- 60 minutes before breakfast, caffeine-containing liquids (e.g. coffee, tea), or other medication (usually prescribed to treat an underactive thyroid). I saw that these tablets were signed as given each morning from 6- 16 December 2021 together with their other nine morning medicines despite the directions stating it must be given 30- 60 minutes before any other medicines. The Levothyroxine tablets may not work effectively and may place the service user's general health at risk of harm if they are not administered in line with the manufacturers' directions.'*

Having had regard to the MAR chart the panel noted that there was nothing to indicate to any of the nursing staff that the Levothyroxine tablet should be given prior to other medications and/or food. The MAR chart simply stated *'ONE to be taken in the MORNING'* with no further instructions. The panel therefore determined that there was insufficient evidence to find this charge proved.

Charge 10.b.iii.

10. In respect of Service User M, failed to ensure that:
    b. The patient's medication was administered safely, in that:
        iii. On 29 October 2021, 1 capsule Amoxycillin 500mg was given at breakfast, lunch, and/or dinner when 2 capsules were prescribed.

This charge is found NOT proved.

In considering this charge the panel had regard to Witness 1's statement which states:

*'I examined the MARS dated 28 October 2021 and saw **SUM** was prescribed Amoxycillin 500mg capsules: two to be taken three times a day for six weeks...The records show that 168 capsules were received on 28 October 2021. Three doses were recorded as given on the 29 October 2021 and a stock balance was recorded against each of the doses showing that after the first dose the balance was 167; the balance after the lunch time dose was 166 and after the teatime dose the balance was 165 capsules. This showed that only one capsule was administered in each dose and the prescriber's directions had not been followed.*

A spot check was recorded as being made on this medicine on the MARS and the comment "nurse made aware" was recorded.'

The panel had regard to the relevant MAR chart and noted that only three tablets were administered on 29 October 2021 instead of the six that were prescribed. The panel noted that it was written on the MAR chart *'nurse made aware'* as a result of a spot check demonstrating that on this occasion there was a system in place to check that medication was administered correctly. It also noted that Ms Lea was not the signatory on the MAR chart that day. The duty to administer the correct dosage to the patient would be on the nurse administering the medication and not Ms Lea. Accordingly, the panel found that Ms Lea had not failed to ensure that the patient's medication was administered safely. It therefore did not find this charge proved.

Charge 10.b.iv.

10. In respect of Service User M, failed to ensure that:
    b. The patient's medication was administered safely, in that:
        iv. On 16 November 2021, a double dose of Ciprofloxacin 500mg was administered, a 1 Ciprofloxacin 500mg tablet went unaccounted for.

The panel found this charge NOT proved.

In considering this charge, the panel had regard to the MAR chart and the statement of Witness 1. It noted from the MAR chart that the numbers recorded in Witness 1's statement did not reflect what was recorded on the MAR chart. It was of the view that the MAR chart provided was not reliable, noting that there were various inconsistencies which could not be explained. It determined that there was insufficient evidence to support Witness 1's assertion that a double dose was given on 16 November 2021 and that one tablet was unaccounted for. There were other possible explanations for the anomalies, the panel therefore found this charge not proved.

Charge 10.c.

10. In respect of Service User M, failed to ensure that:
    c. On 6 December 2021, the patient had Senna 7.5mg as prescribed.

The panel found this charge NOT proved.

In considering this charge, the panel had regard to Witness 1's statement that stated there was no Senna 7.5 mg in stock. It also had regard to the Med Profile for SUM and noted that the medication was PRN (only given as required). However, there was no evidence before the panel to show that Senna 7.5 mg was required by the patient on 6 December 2021. As such the panel found there was insufficient evidence to find this charge proved.

Charge 10.d.i.

10. In respect of Service User M, failed to ensure that:
    d. The patient's care plans were adequate, in that:
        i. The Consent Care Plan did not include a patient specific statement and/or capacity assessment.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUM's Consent Care Plan last updated 8 December 2021.

The panel noted Witness 2's CQC statement that states:

> *'I looked at the care file of SUM. I found that their "Consent' care plan, last updated 08 December 2021, made a blanket and generic statement about their capacity. It stated SUM lacked capacity to make complex decisions regarding her safety and well-being. There was no specific decision identified with regards to this or any capacity assessments to corroborate this statement. This did not comply with the fundamental principles of the MCA that assumes a person has capacity unless proven otherwise.'*

The panel noted that Witness 2's oral evidence was consistent with her written statement. The panel was of the view that Ms Lea, as the Registered Manager of the Home, had a duty to ensure that SUM's Consent Care Plan included a capacity assessment.

The panel had regard to SUM's Consent Care Plan and it noted that a capacity assessment in relation to consent to care was not included within the plan nor had it been provided with separate document detailing this assessment. Regarding a patient specific statement being included in the Consent Care Plan, the panel found that the plan was specific to SUM. The panel acknowledged that it had been provided with capacity assessments in relation to other decisions about SUM's care, however the panel determined that Ms Lea had failed to ensure that SUM's Consent Care Plan included a capacity assessment.

Accordingly, the panel determined that this charge is found proved in relation to the lack of a mental capacity assessment.

Charge 10.d.ii.1-3.

10. In respect of Service User M, failed to ensure that:

d. The patient's care plans were adequate, in that:
    ii. Patient notes included contradictory statements regarding consent, in that:
        1. The Mood and Behaviour care plan suggested the patient had fluctuating capacity,
        2. The 7 April 2020 DNAR, Independent Mental Capacity Advocate report 2 September 2021 and Mental Capacity Assessment 17 September 2021 determined no capacity,
        3. Staff informed the Tissue Viability team that the patient had capacity to understand the risks of not complying with wound care.

This charge is found NOT proved.

In reaching this decision, the panel took into account the following documents:

- SUM's Mood and Behaviour Care Plan, created by a staff nurse at the Home on 6 February 2019 and last updated 8 December 2021;
- SUM's DNACPR created by SUM's GP, dated 7 April 2020;
- SUM's Independent Mental Capacity Advocate ('IMCA') report, created by an IMCA dated 2 September 2021;
- SUM's Assessment of Mental Capacity, undertaken by a Staff Nurse at the Home, dated 27 September 2021; and
- An email dated 16 September 2019, from the Tissue Viability Team ('TVT') Lead Nurse at Wirral Community Health Care NHS Foundation Trust ('the Trust').

The panel had regard to these documents and first noted that the Mood and Behaviour Plan did not make reference to the assertion in charge 16.ii.1. namely, suggesting that SUM had fluctuating capacity.

The panel then considered the remaining documentation and the panel noted that these documents had been created by various health professionals involved in the care of SUM at different times. The panel accepted that these professionals could have

therefore come to different decisions regarding SUM's capacity, particularly as it was accepted that SUM did have fluctuating capacity. The panel concluded that although these decisions appear to be conflicting, it is reasonable to accept that they were accurate reflections of SUM's capacity at those specific times.

The panel also bore in mind that it was not provided with any information in respect of SUM's health at the time these documents were created and it concluded that the author's findings would have been subject to SUM's health and presentation at the material time.

In addition, the panel noted that a multi-disciplinary team was involved in SUM's care and Ms Lea was not responsible for the decisions of other professionals. It therefore concluded that Ms Lea did not fail to ensure the care plans were adequate in this respect.

Accordingly, the panel found this charge not proved.

Charge 10.d. iii.

10. In respect of Service User M, failed to ensure that:
    d. The patient's care plans were adequate, in that:
        iii. No specific mental health and/or dementia care plan was put in place.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2.

The panel noted Witness 2's CQC statement that states:

> *'[…]despite […] concerns regarding SUM's fluctuating capacity and varying ability to understand, and other decisions made in relation to their care, there was no specific mental health care plan or dementia care plan in place to advise staff*

how to support SUM's decision making or mental health. Furthermore, staff had no guidance to follow should specific decisions about SUM's care and treatment need to be made in their best interests. For example, in relation to pressure sore management and safe mobilisation […]'

The panel noted that it had not been provided with evidence to support the assertion that there was a requirement for a specific mental health and/or dementia care plan. The panel also noted that SUM's other care plans did make reference to behaviour associated with their health conditions and ways to address this in a number of their care plans. In all the circumstances, the panel was not satisfied that there was a duty upon Ms Lea to ensure that SUM had a specific mental health and/or dementia care plan in place and accordingly, the panel determined that this charge is found not proved.

Charge 10.d.iv.

10. In respect of Service User M, failed to ensure that:
    d. The patient's care plans were adequate, in that:
        iv. No assessment had taken place for the patient's capacity in respect of a wheelchair safety belt.

This charge is found proved.

In reaching this decision, the panel took into account SUM's Wheel Chair User Risk Assessment dated 9 December 2021 and Witness 2's written evidence.

The panel noted Witness 2's CQC statement that states:

'Safety belt or lap belts as they are commonly known, are used to prevent people from falling out of or sliding out of a wheelchair. Under the MCA, they are considered a form of mechanical restraint, whether the person consents to their use or not. This is because they limit a person's freedom of movement. The MCA should be therefore be followed where there are concerns about a person's

capacity to consent to their use by way of a capacity assessment and best interest process.

SUM was immobile and required the use a wheelchair to mobilise around the home. SUM's wheelchair risk assessment, last updated 09 December 2021, stated to maintain safety whilst in the wheelchair, staff must ensure that the "Safety (lap) belt is used" to secure SUM's position in the wheelchair, […].'

The panel also had regard to SUM's Wheel Chair User Risk Assessment, noting that there was no record in the assessment to confirm that an assessment had taken place for SUM's capacity in respect of a wheelchair safety belt. The panel noted that this was consistent with the evidence of Witness 2. The panel was of the view that there was a duty upon Ms Lea to ensure that SUM had adequate care plans in place. It therefore concluded that Ms Lea failed to ensure that SUM's patient care plans were adequate in that, no assessment had taken place for the patient's capacity in respect of a wheelchair safety belt.

Accordingly, the panel determined that this charge is found proved.

Charge 10.d.v.

10. In respect of Service User M, failed to ensure that:
    d. The patient's care plans were adequate, in that:
        v. No individual plan was put in place for Multiple Sclerosis.

This charge is found NOT proved.

In reaching this decision, the panel took into account SUM's Illness/Medical Condition Care Plan, Consent Care Plan and Mood and Behaviour Care Plan.

The panel acknowledged that whilst there was no individual plan in place for SUM's Multiple Sclerosis ('MS') all the plans above referenced this health condition. Further, the panel noted that SUM's Illness/Medical Condition Care Plan included behavioural

symptoms of MS, examples of symptoms that required escalation to SUM's GP and what medication was prescribed to manage the pain and other associated symptoms of MS. The panel was of the view that this plan was specific to SUM's MS and that this was an adequate care plan. The panel was not provided with any evidence to support the requirement for an individual plan in respect of SUM's MS. In the absence of such information, the panel concluded that Ms Lea did not fail to ensure SUM's care plans were adequate, in that there was no individual plan was put in place for MS.

Accordingly, the panel determined that this charge is found not proved.

Charge 10.d.vi.

10. In respect of Service User M, failed to ensure that:
    d. The patient's care plans were adequate, in that:
        vi. No patient specific details were included in patient plans relating to diabetes.

This charge is found NOT proved.

In reaching this decision, the panel took into account SUM's Illness/Medical Condition Care Plan.

The panel noted that SUM's Illness/Medical Condition Care Plan did make reference to their Type 2 diabetes and whilst it did not detail an individual baseline in respect of their blood sugar indicating their normal blood sugar range, there is some guidance included in the plan which states:

> *'[…] to ensure SUM does not have a hypo low blood sugar level (hypoglycemia) less than 4 mol can mharm SUM if its less tham 3mol [sic] immediate action should be taken. To ensure blood sugar is not too high (hypergylcemia) with levels greater than 10mmol'*

Further, the panel noted that that SUM's Illness/Medical Condition Care Plan included symptoms of Type 2 diabetes, examples of symptoms that required escalation to SUM's GP and what observations were required to be monitored. The panel was of the view that this plan included patient specific details in respect of SUM's Type 2 diabetes and that this was an adequate care plan. The panel determined that Ms Lea did not fail to ensure SUM's care plans were adequate, in that no patient specific details were included in patient plans relating to diabetes.

Accordingly, the panel determined that this charge is found not proved.

Charge 10.d.vii.

10. In respect of Service User M, failed to ensure that:
    d. The patient's care plans were adequate, in that:
        vii. Hyperthyroidism plans lacked clear and/or consistent monitoring information.

This charge is found proved.

In reaching this decision, the panel took into account SUM's Illness/Medical Condition Care Plan.

The panel noted that Hyperthyroidism was included in SUM's listed health conditions. However, it noted that there was nothing specific to SUM which would include examples of symptoms that required escalation to SUM's GP and what medication was prescribed to manage the pain and associated symptoms of Hyperthyroidism. In addition, the panel noted that there was a lack of clear monitoring information. The panel therefore found that this plan lacked clear information in respect of SUM's Hyperthyroidism and accordingly, the panel determined that this charge is found proved.

Charge 10.d.viii.

10. In respect of Service User M, failed to ensure that:

d. The patient's care plans were adequate, in that:

viii. Repositioning records were not completed every 2-3 hours as advised by the Tissue Viability team.

This charge is found NOT proved.

In reaching this decision, the panel took into account the stem of this charge which alleges that Ms Lea failed to ensure that SUM's care plan was adequate. The panel noted the evidence of Witness 2 related to a failure of staff to record when SUM refused repositioning. She also noted that staff were either not following the advice of the Tissue Viability Nurse (TVN) or SUM's wound assessment document to ensure SUM was repositioned at two - three hourly intervals, or were failing to record this.

The panel considered that this evidence did not go directly to the charge in that it did not prove that the care plan was inadequate, rather it is alleged that the staff had not followed the care plan or advice correctly.

Therefore, the panel found this charge not found proved.

Charge 10.d.ix.

10. In respect of Service User M, failed to ensure that:

d. The patient's care plans were adequate, in that:

ix. On 1 and/or 2 December 2021, food and fluid intake records omitted the quantities consumed.

This charge is found NOT proved.

In reaching this decision, the panel took into account the stem of this charge which alleges that Ms Lea failed to ensure that SUM's care plan was adequate. The panel noted the evidence of Witness 2 related to a failure of staff to record SUM's quantity of fluid and food intake on 1 and/or 2 December 2021.

The panel considered that this evidence did not go directly to the charge in that it did not prove that the care plan was inadequate, rather it is alleged that the staff had not followed the care plan or advice correctly.

Therefore, the panel found this charge not found proved.

Charge 10.d.x.

10. In respect of Service User M, failed to ensure that:
    d. The patient's care plans were adequate, in that:
        x. On 11 December 2021, accident and incident records failed to record how the patient was lifted, and/or whether the patient refused to wear their safety belt.

This charge is found NOT proved.

In reaching this decision, the panel took into account the stem of this charge which alleges that Ms Lea failed to ensure that SUM's care plan was adequate and Witness 2's CQC statement that states:

> *'[…] I looked at SUM's Accident and Incident Records. I saw that SUM's physical safety had been compromised by staff on the 11 December 2021, as staff had not followed the person's care plan to ensure they wore their wheelchair safety, belt when it was in motion'*

The panel considered that this evidence did not go directly to the charge, in that it did not prove that the care plan was inadequate, rather it is alleged that the staff had not followed the care plan correctly.

Therefore, this charge is not found proved.

Charge 10.d.xi.

10. In respect of Service User M, failed to ensure that:
    d. The patient's care plans were adequate, in that:
        xi. The COVID-19 risk assessment lack personal details.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUM's COVID-19 risk assessment, last update 9 December 2021.

The panel noted Witness 2's CQC witness statement that states:

> *'I looked at the COVD-19 risk assessments and management plans in place for persons SUM, SUW SUT and SUB. I found them to be extremely limited, generic and meaningless. They did not adhere to the advice set by the Government in respect of ensuring people's individual risks, needs and vulnerabilities being assessed and managed.'*

The panel had regard to SUM's COVID-19 risk assessment and it was of the view that this assessment lacked personal detail. It was almost identical to those of other service users, including generic statements such as *'[…] is over 70 and is classed as vulnerable and high risk'* and it did not outline any specific patient needs or health concerns. In addition, the agreed actions were identical.

Accordingly, the panel determined that this charge is found proved.

Charge 10.e.

e. On 11 December 2021, the patient's wheelchair assessment on the need for a safety belt was followed.

This charge is found proved.

In considering this charge the panel had regard to the statement of Witness 2, and SUM's wheelchair user risk assessment.

It noted the following from the Witness 2's statement:

> *'**SUM** was immobile and required the use a wheelchair to mobilise around the home. **SUM's** wheelchair risk assessment, last updated 09 December 2021, stated to maintain safety whilst in the wheelchair, staff must ensure that the "Safety (lap) belt is used" to secure **SUM's** position in the wheelchair...*
>
> *On the 11 December 2021, Accident and Incident Records indicated that **SUM's** safety belt had not been put on by staff when **SUM** was moved by wheelchair from their bedroom to the lounge. According to the accident and incident record, this resulted in **SUM** attempting to slide themselves out of the wheelchair when in motion. To prevent **SUM** falling from the wheelchair, a staff member had to lower **SUM** to the floor in the lounge area... When Karen Lea was asked about this incident, she told me that **SUM** had refused to wear their safety belt.'*

It was stipulated in SUM's wheelchair user risk assessment that a *'safety belt was to be used'.* The panel accepted the written and oral evidence of Witness 2, that Ms Lea had confirmed that SUM was not wearing a safety belt at the time of the incident on 11 December 2021. The panel therefore determined that staff were not following SUM's wheelchair user risk assessment. The panel took the view that as the registered manager of the Home it was Ms Lea's responsibility to ensure that staff were adhering to the wheelchair user's risk assessment. It therefore found this charge proved.

Charge 10 f.i. and 10.f.ii.

10. In respect of Service User M, failed to ensure that:
    f. The patient's diabetes was adequately monitored, in that:

i. The patient's MAR chart showed no use of GluxoRx Nexus glucose testing strips in October, November, and December 2021,
ii. Between 1 November and 16 December 2021, there was no record of blood glucose testing in the patient's daily records.

These charges are found proved.

In considering these charges the panel had regard to SUM's PRN charts for October, November and December 2021, the Patient Daily Records, and the written and oral evidence of Witness 2.

Based on the evidence of Witness 2, the panel accepted that regular testing of SUM's glucose levels was required in order to monitor SUM's diabetes. The panel had regard to the PRN charts and noted there was no record of GluxoRx Nexus glucose testing strips having been used between October - December 2021. The panel also looked at the Patient Daily Records for SUM and found no entries relating to blood glucose testing between 1 November - 16 December 2021. The panel concluded that, as a result of these omissions, SUM's diabetes was not being adequately monitored during these periods.

The panel considered that as the registered manager, Ms Lea had the responsibility to ensure that adequate monitoring was taking place over this extensive period, given that monitoring glucose is critical for people with diabetes. It therefore found these charges proved.

Charge 10.f.iii.

10. In respect of Service User M, failed to ensure that:
    f. The patient's diabetes was adequately monitored, in that:
        iii. There was no record of HbAC1 testing.

This charge is found proved.

In considering this charge the panel had regard to the written and oral evidence of Witness 2 and the Medical Condition Care Plan. The panel noted that the Medical Condition Care Plan stipulated that SUM required a HbAC1 level test via the GP at least every six months.

The panel had regard to Witness 2's statement which states:

> *'**SUM's** medical care plan stated that **SUM** was to have external HbAC1 tests at least every six months once her diabetes was stable. There was, however, no information pertaining to the stability of **SUM's** diabetes in her care file for staff to determine whether a six-monthly check or more frequent checks were needed. There was also no evidence of any HbAC1 results in **SUM's** care file, daily records, or other care records to show these important blood tests had been undertaken.*
>
> *I asked the Karen Lea on the day of the inspection whether **SUM's** HbAC1 tests had been undertaken. The Appellant was unable to answer. I asked her to investigate this and provide evidence that **SUM's** HbAC1 tests had been undertaken as required. I also emailed the Appellant requesting the same information on the 22 December 2021... The Appellant responded on the 24 December 2021 by email confirming that **SUM's** diabetes was diagnosed in March 2021 and that blood samples had been taken in June 2021,but provided no evidence of this or evidence of any other tests... The lack of HbAC1 testing information was concerning as it meant staff did not have any up-to-date information on the status of **SUM's** diabetic condition and whether risks in relation to this condition were being effectively managed.'*

The panel accepted the evidence of Witness 2, that there was no record of HbAC1 testing, and that this was confirmed to her by Ms Lea on the day of the inspection. The panel accepted that this test is required to adequately monitor SUM's diabetes.

The panel considered that as the registered manager, Ms Lea had the responsibility to ensure that adequate monitoring was taking place over this extensive period, given that

regular HbAC1 testing was necessary in order to adequately monitor SUM's diabetes. It therefore found this charge proved.

Charge 10.f.iv.

10. In respect of Service User M, failed to ensure that:
    f. The patient's diabetes was adequately monitored, in that:
        iv. There was no record of the patient attending the diabetic foot clinic.

This charge is found NOT proved.

In considering this charge the panel had regard to an email dated 11 August 2021 from the Home to the TVT and the written and oral evidence of Witness 2.

The panel had regard to Witness 2's evidence that she had checked SUM's care file, daily records and other care records for evidence that SUM attended the diabetic foot clinic and could not find any records. Witness 2 did not state how far back she had looked in the records, and there is no date specified in the charge, nor does the charge specify the type of record required. When Witness 2 asked Ms Lea for evidence that SUM had attended the diabetic foot clinic, Ms Lea provided her with the email of 11 August 2021 which states:

'Good afternoon…

…she was discharged from yourselves with a wound management plan. she was then going to a diabetic foot clinic in Arrowe park hospital. they then discharged her as they felt we could manage this at home…'

The panel determined that although the email gave no detail regarding the specific dates that SUM attended the diabetic foot clinic, it was a record confirming SUM's attendance at the clinic. Accordingly, the panel found this charge not proved.

Charge 10.g.i.

10. In respect of Service User M, failed to ensure that:
    g. Weight recordings were adequate, in that:
        i. On 2 February 2021, the patient was measured as weighing 68.5kgs,
        ii. On 5 February 2021, the patient was measured as weighing 92.7kgs,
        iii. On 23 February 2021, the patient was measured as weighing 92.7kgs,
        iv. No explanation was given for the changes in weight.

These charges are found NOT proved.

The panel considered whether Ms Lea had failed to ensure that the weight recordings were adequate. The panel was not provided with SUM's weight records and Witness 2 did not state who was responsible for taking those records. It was clear to the panel from Witness 2's statement that these were recording errors and could not be an accurate record of SUM's weight changes. The panel determined that Ms Lea could not be held responsible for monitoring all of the weight recordings for every single resident within the Home over a three-week period and should have been able to rely on staff to alert her if there were significant weight changes in respect of any of the residents. It therefore found these charges not proved.

Charge 10.h.i

10. In respect of Service User M, failed to ensure that:
    h. Skin Care plans were adequate, in that:
        i. The patient's Braden Scale Risk Assessment, dated 8 December 2021, and/or Pressure Sore Risk Assessment, dated 9 December 2021, failed to consider the patient's existing sores.

This charge is found NOT proved.

In reaching this decision, the panel took into account SUM's Braden Scale Risk Assessment dated 8 December 2021, SUM's Pressure Sore Risk Assessment dated 9 December 2021 and the evidence of Witness 2.

The panel noted Witness 2's CQC statement that states:

> *'I looked at the skin and wound care provided to SUM. SUM had several pressure sores already in place. I looked at her Braden Scale risk assessment for pressure sore development which stated she was at medium risk of pressure sores. […]This contradicted with another pressure sore risk assessment in SUM's file which stated her risk of pressure sore development was high. […]*
>
> *This was confusing and did not give a clear indication of SUM's level of risk. Furthermore, neither risk assessment appeared to take into account SUM's existing pressure sores, which clearly indicated that SUM's risk of developing additional wounds was serious and significant.'*

The panel had regard to the assessments specified in the charge and noted there were two different types of assessments. The panel had not been provided with, or heard any live evidence in respect of, how these assessments were conducted and what was required to be taken into account for each assessment. The panel bore in mind that the burden of proof rests upon the NMC and in the absence of further evidence to support the assertion in the charge, the panel did not find this charge proved.

Charge 10.h.ii.

10. In respect of Service User M, failed to ensure that:
    h. Skin Care plans were adequate, in that:
        ii. The Skin Care Plan included contradictory information regarding the number of wounds.

This charge is found proved.

In reaching this decision, the panel took into account SUM's Skin Care Plan last updated 10 December 2021.

The panel note that on this plan in the section labelled *'condition'* it described three wounds, namely:

> ***'Condition***
> *SUM has a deep tissue injury to her right heel and is therefore at risk of infection and malnutrition*
> *SUM has a deep tissue injury to her left heel and is therefore at risk of infection and malnutrition.*
> *Her left big toe is blackened'*

However, further down the plan under the heading '*action'* five wound sites are described as right heel, right inner heel blister, left heel, left calf and left big toe.

The panel noted that the first section of the plan under the heading '*condition'* did not make reference to the number of wounds that were being managed under the heading *'action'*. The panel considered that as the Registered Manager of the Home, Ms Lea had the responsibility to ensure that there was a system in place to check that care plans were adequate, followed and frequently reviewed to ensure they were up to date and accurate.

The panel was of the view that this information was contradictory regarding the number of wounds SUM had and accordingly, the panel determined that this charge is found proved.

Charge 10.h.iii. and 10.h.iv.

10. In respect of Service User M, failed to ensure that:

h. Skin Care plans were adequate, in that:
    iii. Staff failed to follow the Tissue Viability team's advice following assessments on 25 August 2020 and/or 5 February 2021,
    iv. On 24 and 26 November, and 2 December 2021, wound assessments failed to include accurate information on wound size and/or include photographs of wounds.

These charges are found proved.

In reaching this decision, the panel took into account SUM's Skin Care Plan last updated 10 December 2021, the TVN's wound assessment reports dated 25 August 2020 and 5 February 2021.

The panel noted that the TVN had issued advice following assessments on 25 August 2020 and 5 February 2021 that had not been added to the care plan. It noted that this advice included; repositioning SUM every 2-3 hours, daily monitoring of clinical observations (including recording the size of the wounds) ensuring all documentation is completed clearly and accurately (repositioning and dietary intake charts), recording SUM's refusal of repositioning and completing weekly wound assessments including clinical photography.

The panel had regard to the entries made for the dates specified in charge 10.h.iv. and noted that there was no information provided in respect of the size of wounds nor were photographs of the wounds included in the records.

The panel considered that as the Registered Manager of the Home, Ms Lea had the responsibility to ensure that there was a system in place to check that care plans were adequate, followed and frequently reviewed to ensure they were up to date and accurate.

Accordingly, the panel determined that these charges are found proved.

Charge 10.i.i. and 10.ii.

10. In respect of Service User M, failed to ensure that:
    i. Dressings were adequately changed, in that:
        i. On 5 December 2021, a dressing was changed a day late,
        ii. On 9 December 2021, a dressing was changed 2 days late.

These charges are found NOT proved.

In reaching this decision, the panel took into account SUM's daily records dated from 1 November to 16 December 2021 and the evidence of Witness 2.

The panel noted Witness 2's CQC statement that states:

> *'The wound assessment and treatment plans dated 10 December 2021 […] 02 December, 26 November and 24 November 2021 advised nursing staff to redress SUM's wound every other day unless exudate or odour was present when it should be changed daily. I looked at the records relating to SUM's dressing changes and found that SUM's wounds were not re-dressed every other day as required.[…]'*

The panel had regard to SUM's daily records and noted that the dressing in respect of charge 10.i.i. was due to be changed on 3 December, not 4 December 2021. The panel noted that there was no record of the dressing being changed on 4 December 2021, therefore it found that this dressing was changed two days late. Further, the panel found that the daily records confirm that the dressing in respect of charge 10.i.ii. was changed two days late.

There was no evidence to suggest that Ms Lea was the nurse changing SUM's dressings during this period. Whilst the panel accepted the seriousness of this charge, the panel considered that the registered nurses at the Home were responsible for their own clinical practice and it was reasonable for Ms Lea to expect them to change SUM's dressings in accordance with their care plan. These incidents occurred twice during a

four-day period and Ms Lea could not be expected to have daily oversight of each nurse's clinical practice and each resident's daily records. In the circumstances it would be placing too high a standard of responsibility on Ms Lea for the panel to find that she failed to ensure that SUM's dressings were adequately changed on 5 and 9 December 2021.

Accordingly, these charges are found not proved.

Charge 10.i.iii.

10. In respect of Service User M, failed to ensure that:
    i. Dressings were adequately changed, in that:
        iii. Records failed to clearly identify which dressings had been changed.

This charge is found proved.

In reaching this decision, the panel took into account SUM's daily records dated from 1 November to 16 December 2021.

The panel had regard to SUM's daily records and it noted that the records, on many occasions, did not clearly identify which dressing had been changed, or make clear refence to the individual wounds. For example, an entry on 5 December 2021 at 19:18 states: '*dressings changed to leg and heel this afternoon as per wound assessment6 [sic] no concerns expressed'.* The panel was of the view that staff members reviewing these notes would be unable to clearly identify what dressings had been changed and therefore, subsequent management of the wounds may have been inadequate. The panel noted that wound care records were not adequately maintained over a six-week period. The panel concluded that there was a duty upon Ms Lea as the Registered Manager of the Home to ensure that systems were in place to maintain accurate wound care records so that wounds could be managed safely.

Accordingly, the panel determined that this charge is found proved.

Charge 10.j.

10. In respect of Service User M, failed to ensure that:
    j. In December 2021, the patient had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted that Witness 1's CQC witness statement states:

> *'At this inspection, I found that [Ms Lea and the Registered Provider] had also failed to put a system in place to ensure that service users allergy status was recorded. This is an ongoing concern from the inspection in May 2021. I examined the MARS sheets and Meds Profiles for 13 service users and saw that allergy status section was not completed for six service users. SUN, SUU, SUM, SUV, SUP and SUF. It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to.'*

The panel noted that Witness 1's evidence regarding service users' allergy statuses had been credible and consistent. The panel noted that '*no known allergies'* was recorded on some of SUM's care plans. However, these documents would not be checked when administering medication when information about allergy status was most important. No information about allergy status was recorded on the MAR charts or Med Profiles viewed by the panel. The panel was therefore satisfied that Ms Lea had failed to ensure in December 2021 that SUM had an up-to-date allergy status in the relevant places in the notes. It therefore found this charge proved.

Charge 11. a. i.

11. In respect of Service User N, failed to ensure that:
    a. Medicine was appropriately administered, in that:
        i. There were no records to show Daktacort had been applied.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and a photograph of Service User N's ('SUN') Interim Topical PRN Chart dated 17 December 2021.

The panel noted Witness 1's CQC statement:

> *'… On 20 December 2021 I saw there was an unopened tube of Daktacort – Miconazole 2%/Hydrocortisone 1% Ointment labelled for **SUN**, dated as dispensed on 17 December 2021. Daktacort ointment is used to treat inflamed conditions of the skin such as eczema and dermatitis which may be caused by infection with certain fungi and bacteria. **SUN's** Interim Topical PRN chart dated 17 December 2021 showed that two tubes had been received on that date… The directions for use were that it should be applied thinly twice daily… I saw that there were no records to show that the ointment had been applied. This ointment contained a steroid, the ointment would be applied by nurses not carers who would only apply emollients and barrier creams, this was confirmed by the Karen Lea who was on duty administering medicines on the 20 December 2021. I asked her if she had applied Daktacort Ointment. She told me she was unaware **SUN** required the ointment and she would have to find out… This concerned me because she was the nurse in charge and should have been aware of the nursing needs of each service user… I saw that there were no notes recorded on the MAR to show that this ointment had been offered and refused by **SUN**. Her reply further concerned me because the ointment was to treat an infection and was not a barrier cream and delay in applying the ointment placed the service*

users skin integrity at risk. There were no records made to show that the ointment had been refused in preference to another cream…'

The panel was of the view that, having regard to a photograph of SUN's Interim Topical PRN Chart, it showed that no Daktacort had been administered to SUN.

Accordingly, the panel determined that this charge is found proved

Charge 11. a. ii.

11. In respect of Service User N, failed to ensure that:
    a. Medicine was appropriately administered, in that:
        ii. Records showed that Mediderma was only applied on 5 of 10 nights when it was required more frequently.

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC statement:

*'… I saw that **SUN** also had a barrier cream prescribed (Mediderma) and the PRN protocol to support the application of the cream showed that they were prone to reddened areas to his buttocks and groins due to moisture, the cream should be applied at pad changes to protect the skin… On examination of the PRN chart dated 6 December 2021 for the application of Mediderma I saw it showed that the use of the barrier cream was only applied on five nights over a period of 10 days prior to the reports of the reddened groin. Failure to apply barrier creams at the times advised (each pad change) potentially placed **SUN** at risk of becoming infected…'*

The panel noted that Witness 1 stated that the PRN medication was only given five out of ten nights. Witness 1 also stated that giving the PRN medication five out of ten nights

was inappropriate. However, because it is a PRN medication, the panel concluded it may have been appropriate to administer over five nights as it is prescribed as PRN '*as required*' as opposed to being administered as a regular and routine prescribed dose.

The panel noted that it has no Med profile chart to show that the medication should be given to SUN every day, nor does it have any evidence to explain why applying the medication over five nights, as opposed to ten nights, would be inappropriate.

Therefore, there is nothing before the panel to suggest that there was a responsibility to administer the PRN medication to SUN more frequently than it was.

Accordingly, the panel determined that this charge is found not proved.

Charge 11. b.

11. In respect of Service User N, failed to ensure that:
    b. Hypromellose eye drops, prescribed in October 2021, were in stock.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC statement:

> *'… On 16 December 2021, I examined **SUN's** Med Profile on 6 December 2021 and saw that they prescribed Hypromellose eye drops, lubricating drops for dry eyes, to be used PRN but none were recorded as being sent, received or brought forward from a previous cycle. I also observed that none were in stock. The nurse on duty **Staff member T** confirmed that there were no eye drops in stock. **Staff member T** told me that that the drops had been prescribed by the optician. **Staff member T** said the optician had prescribed the drops at the end of October 2021 and they should be on repeat prescription if the GP was in agreement. We asked Karen Lea to find out if the drops had been obtained since they were*

*prescribed. They responded that "Client did receive eye drops when first prescribed but did not require however there has been a new prescription issues", however there was no supporting information to show the drops had been received initially or that they had the drops in stock in the home. I noted that the we were told that the prescriber had issues a new prescription it is concluded that **SUN** needed these drops and was at risk of experiencing discomfort when they were not available…'*

The panel accepted that no eye drops were in stock as Witness 1 spoke to Ms Lea who confirmed this was the case.

Accordingly, the panel determined that this charge is found proved.

Charge 11. c.

11. In respect of Service User N, failed to ensure that:
    c. In December 2021, the patient had an up-to-date allergy status in their notes.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUN's PRN Plan for Mediderma.

Witness 1 in her written statement to CQC had listed a number of service-users where their allergy status was not recorded and included SUN in this list. However, the panel had regard to SUN's PRN chart in December 2021, on which was recorded that there were:

'no known allergies'.

The panel determined this was an up-to-date record of their allergy status and, determined that this charge is found not proved.

Charge 12. a. i.

12. In respect of Service User P, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        i. Between 23 November and 7 December 2021, Nystan oral suspension was recorded on the patient's MAR chart with "o" without explanation.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of, and a photograph of Service User P's ('SUP') MAR chart, showing Nystan, dated from 23 November 2021.

In her oral evidence, Witness 1 explained to the panel that recording "*o*" without explanation, would be unclear to the next nurse on shift whether the medication had been administered or not or if it signified something else.

The panel noted, "*o*" recorded without any explanation and accepted Witness 1's evidence about the difficulties this presented.

Accordingly, the panel determined that this charge is found proved.

Charge 12. a. ii.

12. In respect of Service User P, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        ii. Between 23 November and 7 December 2021, on one or more occasion, administered Nystan oral suspension 51mls when only 30mls were available.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and a photograph of SUP's MAR chart, showing Nystan oral suspension dated 23 November 2021.

The panel was made aware according to the chart there was a total of 30mls of Nystan in stock and yet it was recorded that SUP was administered 51mls between 23 November and 7 December 2021.

Accordingly, the panel determined that this charge is found proved.

Charge 12. b. i.

12. In respect of Service User P, failed to ensure that:
    b. Medication was properly disposed of, in that:
        i. 1 or more tubes of Biotene gel and/or a Hydroxocobalamin injection were left on a work surface.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC statement:

> *'…I saw other unwanted machines were not stored safely; Cosmocal sachets dispensed 29 September 2021 belong to **SUQ** and two tubes of Biotene gel dispensed on 8 December 2021 and a Hydroxocobalamin injection dispensed on 6 August 2021 belonging to **SUP** had been left on the work surface and had not been disposed of properly. The Registered Manager explained to me that both the Service Users had died and they had "not got round" to disposing of their medicines. She explained that **SUP's** medicines arrived with the monthly medicines after they had died. If medicines are not stored safely, they could be misappropriated or misused placing Service Users at risk of harm…'*

The panel noted it does not have any exhibits before it to support this charge but accepted Witness 1's account and that Ms Lea confirmed that the Home had not stored the medications appropriately.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 12. c.

12. In respect of Service User P, failed to ensure that:
    c. In May 2021 and/or December 2021, the patient had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence, including Witness 1's written CQC statement dated 30 March 2022.

The panel noted Witness 1's CQC statement:

> *'I examined the MARS sheets and Meds Profiles for nine service users and saw that [the] allergy status section was not completed for six service users* ***(SUA, SUP, SUD, SUG, SUF, SUH)****. It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to*.'

The panel noted that Witness 1's evidence was also consistent with her oral evidence. The panel had regard to SUP's Interim Chart and noted that that there was nothing recorded in the allergies or notes section.

The panel concluded that Ms Lea failed to ensure in May 2021, that SUP had an up-to-date allergy status in their notes.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 13

13. In respect of Service User Q, failed to ensure that, Cosmocol sachets, dispensed on 29 September 2021, were properly disposed of.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC statement:

> *'…I saw other unwanted machines were not stored safely; Cosmocal sachets dispensed 29 September 2021 belong to **SUQ** and two tubes of Biotene gel dispensed on 8 December 2021 and a Hydroxocobalamin injection dispensed on 6 August 2021 belonging to **SUP** had been left on the work surface and had not been disposed of properly. The Registered Manager explained to me that both the Service Users had died and they had "not got round" to disposing of their medicines. She explained that **SUP's** medicines arrived with the monthly medicines after they had died. If medicines are not stored safely, they could be misappropriated or misused placing Service Users at risk of harm…'*

The panel noted it does not have any exhibits before it to support this charge but accepted Witness 1's account and that Ms Lea confirmed that the home had not stored the medications appropriately.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 14. a. i. and Charge 14. a. ii.

14. In respect of Service User R, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        i. On 8 November 2021 and/or 6 December 2021, the medication profile for a DuoResp inhaler showed that no inhalers had been sent, received, or brought forward, when 1 was dispensed on 29 September 2021, and on 16 December 2021, had doses remaining,
        ii. Between 11 November and 15 December 2021, the MAR chart for the DuoResp recorded 133 doses as administered when the medication profile showed only 1 inhaler, containing 60 doses, in stock.

Charges 14. a. i, and 14. a. ii are found proved.

The panel decided to group charges 14. a. i and 14. a. ii together as they related to the same evidence, namely the evidence of Witness 1, Service User R's ('SUR') Medication Profile showing DuoResp dated 8 November 2021, SUR's Medication Profile showing DuoResp dated 6 December 2021, and a photo of the box for SUR's DuoResp inhaler (showing 16 doses).

The panel noted Witness 1's CQC statement:

> *'…On 16 December 2021 I saw **SUR** was prescribed DuoResp Inhaler; one dose to be inhaled twice daily… I examined their Med Profile for the cycle commencing 11 October 2021 and saw that one inhaler had been received… I then examined their Med Profile for the cycle commencing 8 November 2021 which showed that no DuoResp inhalers were sent or received or brought forward… I examined their Med Profile for the cycle commencing 6 December 2021 which also showed that no DuoResp inhalers were sent or received or brought forward… However, I saw there was one inhaler in stock which had been dispensed on 29 September 2021 and the counter on the inhaler showed there were 16 doses remaining in the inhaler… The MAR charts showed that the DuoResp inhaler had been administered twice daily 11 October 2021 to 15 December 2021 and once on the*

morning of 16 December 2021. This means that 133 doses had been signed as administered in that period. I asked Karen Lea if there were any other inhalers in stock for this service user or if any other inhalers had been received. I was told this was the only inhaler in stock and they could not tell if any other inhalers had been received as there were no records to show receipt, so they assumed no other stock had been received. There are 60 doses in an inhaler. It is impossible to administer 133 doses from one inhaler. It was not possible to conclude that the inhaler was administered as prescribed only that some aspect(s) of record keeping were inaccurate. If the inhaler had not been administered as prescribed the service user was at risk of experiencing breathing problems…'

The panel noted having regard to SUR's Medication Profiles dated 8 November and 6 December 2021, that there was no record of DuoResp inhalers being sent, received or brought forward in November or December. The panel also observed that there were 16 doses remaining in the inhaler which was dispensed in September 2021. The panel accepted Witness 1's evidence that 133 doses that were recorded as having been administered between 11 November to 15 December 2021 could not have been administered from one inhaler as each inhaler contains only 60 doses. In addition, Ms Lea confirmed to Witness 1 there were no other DuoResp inhalers in stock at the Home during this period. The panel concluded therefore, that the records were inaccurate.

Accordingly, the panel determined that charges 14. a. i and 14. a. ii are found proved on a balance of probabilities.

Charge 14. a. iii.

14. In respect of Service User R, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        iii. No date of opening was recorded for the DuoResp inhaler.

This charge is found proved.

The panel took account of the photograph of the DuoResp inhaler and the evidence of Witness 1 when concluding there was no date of opening recorded on the box or the inhaler. Therefore, this charge is found proved.

Charge 14. a. iv. and Charge 14. a. v.

14. In respect of Service User R, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        iv. On 8 November 2021 and/or 6 December 2021, the medication profile for Cosmocol sachets showed that no sachets had been sent, received, or brought forward, when a box of 30 was dispensed on 29 September 2021, and on 16 December 2021, sachets were remaining,
        v. Between 11 November and 15 December 2021, the MAR chart for the Cosmocol sachets recorded 50 doses as administered when the medication profile showed only 30 sachets in stock.

Charges 14. a. iv and 14. a. v are found proved.

The panel decided to group charges 14. a. iv and 14. a. v together as they related to the same evidence, namely the evidence of Witness 1, SUR's MAR chart dated 8 November 2021, SUR's Med Profile showing Cosmocol dated 8 November 2021, and SUR's Med Profile showing Cosmocol dated 6 December 2021.

The panel noted Witness 1's CQC statement:

> *'… On 16 December 2021, I saw that **SUR** was also prescribed Cosmocol sachets one to be taken each day (for constipation). I examined their Med Profile for the cycle commencing 11 October 2021 and saw that 30 sachets had been recorded as received and none carried forward. I then examined their Med Profile for the cycle commencing 8 November 2021 which showed that no Cosmocol Sachets were recorded as sent, received or brought forward. I examined their Med Profile for the cycle commencing 6 December 2021 which also showed that no Cosmocol were sent or received or brought forward… However, I saw there*

were 11 in a box labelled for this Service User which showed that 30 sachets had been dispensed on 29 September 2021… I asked Karen Lea if any other Cosmocol were in stock or had been delivered since 29 September 2021 and she told me that none had been delivered since that date and the box in the home was the only stock they had. She confirmed that the quantity in the home had not been carried forward and the records were inaccurate… I examined ***SUR's*** *MARs from 11 October 2021 to 16 December 2021… The records show that only 30 had been recorded as received and Karen Lea confirmed this. It is impossible to administer 50 doses from a box containing 30 sachets. It was not possible to conclude that the laxative was administered as prescribed only, that some aspect(s) of record keeping were inaccurate… the Service User was at risk of experiencing uncomfortable constipation symptoms…'*

The panel noted that, having regard to SUR's Med Profile, showing Cosmocol, dated 8 November 2021, there were no Cosmocol sachets recorded as being in stock and yet, it was recorded that Cosmocol continued to be administered until 6 December 2021, despite none being recorded as sent, received or brought forward in November 2021.

The panel also noted that, having regard to SUR's Medication Profile, showing Cosmocol, dated 6 December 2021, no Cosmocol sachets were recorded as being in stock. It concluded that the Medication Profiles show no Cosmocol sachets were received but it continued to be administered.

Accordingly, the panel determined that both charges 14. a. iv and 14. a. v the records were inaccurate and therefore, these charges are found proved on a balance of probabilities.

Charge 14. a. vi.

14. In respect of Service User R, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        vi. On 11 October 2021, the medication profile for Epimax cream showed that 500mg had been received; none was sent, received, or brought

forward on 8 8 November 2021 and/or 6 December 2021, and there was no record of the Epimax cream being applied.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, and SUR's Med Profiles for 11 October 2021, 8 November 2021 and 6 December 2021.

The panel noted Witness 1's CQC statement:

> *'… I examined **SUR's** Meds Profile dated 11 October 2021 which showed that 500g Epimax Cream had been recorded as received… I examined the Meds Profile dated 8 November 2021 and 6 December 2021 which showed none had been recorded as received or brought forward… On 16 December 2021 I asked Karen Lea where the records for the application of Epimax were and where the cream was. She told me she did not know why there were no records for the application of the cream, and she told me she would have to check in her room to see if there was any in stock. She did not report that there was any cream in **SUR's** bedroom and did not provide any records of administration. Epimax is usually prescribed as emollient for the relief of dry skin in eczema, psoriasis and other dry skin conditions and can be used as a soap substitute. If the cream is not applied their skin is at risk of breakdown…'*

Having viewed the relevant Med Profiles, the panel accepted Witness 1's evidence that there was no Epimax cream recorded as being sent, received or brought forward in November or December 2021. Nor was there any record of the Epimax cream being applied. When questioned by Witness 1 during the CQC inspection, Ms Lea was not able to provide any explanation why there was no Epimax cream being recorded as in stock or any record of it being applied.

Accordingly, the panel determined that this charge is found proved.

Charge 14. a. vii.

14. In respect of Service User R, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        vii. The MAR chart for Zapain 30/500mg did not show the time the medicine was administered.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's oral evidence and SUR's MAR chart dated 11 October 2021.

The panel noted that on SUR's MAR chart there are directions from the pharmacist stating:

> *'TWO to be taken in the morning, ONE to be taken at LUNCHTIME, ONE to be taken at TEATIME and TWO to be taken in the EVENING'*

Witness 1 in her oral evidence explained to the panel that Zapain contains paracetamol that should not be taken more than every four hours, so the times of administration should be recorded on the MAR chart. The panel noted that the Home had followed the pharmacist instructions which provided a framework with the appropriate time intervals and administered this medication accordingly.

Therefore, the panel determined that this charge is found not proved on a balance of probabilities.

Charge 14. b. i.

14. In respect of Service User R, failed to ensure that:
    b. The patient's medication was administered safely, in that:
        i. Between 6 and 16 December 2021, Lansoprazole 30mg and Mebeverine 135mcg were administered without regard to manufacturer's directions,

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUR's MAR chart dated 6 December 2021.

The panel noted Witness 1's CQC statement:

> *'On 16 December 2021, I examined the MAR chart for SUR together with their pack of morning medicines and saw that they were prescribed Lansoprazole 30mg capsules to be taken daily 30-60 minutes before food (usually prescribed to treat or prevent stomach ulcers) and Mebeverine 135mg tablets; to be taken three times daily, preferably 20 minutes before food […] .Both these tablets were recorded as given each morning from 6 and 16 December 2021 and Karen Lea confirmed to me that these medications had been given with no regard for the manufacturer's directions. If the manufacturer's directions are not followed the medicines maybe ineffective and this would put the service user's health at risk of developing stomach ulcers and they may suffer stomach cramps unnecessarily.'*

When looking at SUR's MAR chart, the panel noted that there were no records of the medications being administered 30 and 20 minutes respectively, prior to eating. Additionally, Ms Lea confirmed to Witness 1 that the medications were given without regard to the manufacturer's directions.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 15. a. i.

15. In respect of Service User S, failed to ensure that:
    a. Accurate records of medication were kept, in that:

i. On 10 November 2021, the medication profile for Warfarin 1mg showed 82 tablets remaining when administration records suggested that 96 should have been remaining.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, Service user S's ('SUS') Warfarin Chart dated 11 October 2021 and SUS's Warfarin Chart dated 8 November 2021.

The panel noted Witness 1's CQC statement:

> *'… I saw there was a system in use for accounting for the Warfarin stock to show the correct doses of Warfarin had been administered. The Warfarin Chart dated 11 October 2021 recorded that 98 x Warfarin 1mg and 112 Warfarin 3mg tablets remained at the end of the cycle on 7 November 2021… The count on 10 November after the first dose of 2 x 1mg tablets was given was recorded as 82 tablets (instead of the expected 98 minus two tablets= 96) indicating 14 x warfarin 1mg tablets were unaccounted for…'*

The panel accepted Witness 1's evidence and it was satisfied that this was supported by SUS's Warfarin chart which showed that 14 tablets were unaccounted for.

Accordingly, the panel determined that this charge is found proved.

Charge 15. a. ii.

15. In respect of Service User S, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        ii. On 29 November 2021, the medication profile for Warfarin 1mg showed 92 tablets remaining when administration records suggested that 78 should have been remaining.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUS's Warfarin Chart dated 8 November 2021.

The panel noted Witness 1's CQC statement:

> *'… Warfarin 1mg tablets were recorded as given on the 17 and 24 November, a total of four tablets were recorded as given and the balance was recorded as 78 tablets. No further 1mg tablets were recorded as given until 2 December 2021. However, on 29 November the recorded quantity of 1mg tablets was increased to 92, there were no records to explain why the balance had increased by 14 tablets from 78 to 92 tablets…'*

With regard to SUS's Warfarin chart, the panel was satisfied that no explanation was recorded in relation to the inaccuracies of Warfarin stock within the Home. In particular, there was no reference to the 14 tablets being found. The panel therefore concluded that there was an inaccurate record.

Accordingly, the panel determined that this charge is found proved.

Charge 15. a. iii.

15. In respect of Service User S, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        iii. On 5 December 2021, administration records suggested that neither Warfarin 1mg nor 3mg had been administered.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1, SUS's Warfarin Chart dated 8 November 2021 and SUS's Warfarin Dose Schedule dated 1 December 2021.

The panel noted Witness 1's CQC statement:

> *'… No record was made of any tablets of either strength being given on 5 December 2021; the MARS was blank. The dosing schedule supplied by the Warfarin Monitoring Service commencing 1 December 2021 was to omit the dose on Wednesday 1 December 2021 and to give 2mg on the next three days and on Sunday 5 December the dose was 3mg, there was no instruction to omit the dose on 5 December 2021…'*

With regard to SUS's Warfarin Chart (the MAR chart for Warfarin) the panel found that Warfarin was not recorded as being administered on 5 December 2021 despite being prescribed.

The panel therefore concluded that the Warfarin was not administered safely, but it found that the records were accurate, in that it was not administered.

Accordingly, the panel determined that this charge is found not proved.

Charge 15. a. iv.

15. In respect of Service User S, failed to ensure that:
    a. Accurate records of medication were kept, in that:
        iv. On 6 December 2021, the medication profile for Warfarin 1mg and/or Warfarin 3mg showed 28 tablets in stock, failing to show the quantity brought forward.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUS's Med Profile, showing Warfarin, dated 6 December 2021.

The panel noted Witness 1's CQC statement:

'[…] The Warfarin Chart dated 6 December 2021 shows that 114 Warfarin 1mg tablets had been available for administration at the start of the cycle (86 from the previous cycle and 28 received for this cycle). It was recorded that 120 Warfarin 3mg tablets had been available for administration at the start of the cycle (92 from the previous cycle and 28 received for this cycle) […]'

'I also looked at the Med Profile chart dated 6 December 2021 and saw that the records were inaccurate because the quantity of warfarin recorded as being in the home was 28 tablets of each strength, there was no record that tablets had been brought forward from the previous cycle.'

The panel considered SUS's Med Profile that confirmed 28 1mg and 3mg Warfarin tablets had been sent but the tablets from the previous cycle as outlined in Witness 1's statement above, had not been recorded as brought forward.

Accordingly, the panel determined that this charge is found proved.

Charge 15. b.

15. In respect of Service User S, failed to ensure that:
    b. The PRN protocol for Zapain included guidance as to the intervals between doses.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUS's Zapain PRN protocol dated 18 October 2021.

The panel noted Witness 1's CQC statement:

'… None of these statements provide clear guidance about when and why this medicine would be required or what prompting was needed. There was also no

information to guide nurses as to the circumstances each dose would be selected. I also noted that the minimum interval between each dose should be "eight hours". This information was incorrect…'

The panel had sight of the PRN protocol and noted there is recorded the reason for administration, guidance on the minimum time between doses, the frequency of doses and administration information. Therefore, the panel determined this was adequate guidance (albeit it accepted Witness 1's evidence that the time between doses was incorrect).

Accordingly, the panel determined that this charge is found not proved on a balance of probabilities.

Charge 16.a.i.

16. In respect of Service User T, failed to ensure that:
    b. Medication was given as prescribed, in that:
        i. Between 1 October and 30 November 2021, Bioxtra gel and/or Viscotears were not administered as prescribed.

This charge is found proved in relation to the administration of Bioxtra gel.

In reaching this decision, the panel took into account Service User T's ('SUT') MAR charts dated 1- 28 October 2021 and 2-30 November 2021, SUT's hospital discharge letter dated 30 September 2021 and the evidence of Witness 1.

The panel took into account Witness 1's CQC statement that states:

'I examined SUT's MAR charts dated 1- 28 October 2021 and 2-30 November 2021. […] I saw they recorded that Bioxtra dry mouth gel was prescribed to be given four times daily, and the records showed it was not always given as prescribed. The MAR chart dated 2-30 November 2021 also showed Viscotears were prescribed to be given [PRN]'

The panel had regard to SUT's MAR chart noting that between 1 October and 30 November 2021, Bioxtra gel was not always signed for as administered four times a day, as per the prescription instructions. The panel noted there was no explanation recorded on the MAR chart to explain why this medication was not administered. The panel considered that this was consistent with the evidence of Witness 1 and accepted her evidence in this regard. Although Ms Lea was not the nurse administrating the medication, as the Registered Manager of the Home the panel considered that over an eight-week period, Ms Lea had responsibility to ensure that adequate systems were in place to ensure medication was administered as prescribed.

In relation to the administration of Viscotears, the panel acknowledged that this was not always administered daily between 1 October and 30 November 2021. However, the panel had regard to SUT's hospital discharge letter dated 30 September 2021, including the list of SUT's prescribed medications. It noted that the instructions given for the administration of Viscotears stated: '*if necessary, As required for dry eyes'*. In light of these instructions, the panel accepted that this was a PRN medication and therefore, there was no requirement for this medication to be administered daily.

Accordingly, the panel found that between October and 30 November 2021 Bioxtra gel was not administered as prescribed. The panel did not find that Ms Lea failed to ensure that Viscotears medication was administered between October and 30 November 2021, for the reasons set out above.

Charge 16.a.ii.

16. In respect of Service User T, failed to ensure that:
    a. Medication was given as prescribed, in that:

        ii. On 29 November 2021, include Bioxtra gel and/or Viscotears were out of stock.

This charge is found proved.

In reaching this decision, the panel took into account SUT's MAR chart dated 2-30 November 2021 and the evidence of Witness 1.

The panel took into account Witness 1's CQC statement that states:

> *'When I examined the MAR charts dated 6 December 2021 neither medicine was listed and I saw there was no stock of either medicine in the home. I asked Karen Lea if they were still prescribed and she told me she didn't know and would have to find out. After the inspection visits Karen Lea confirmed that the GP had now prescribed the dry mouth gel and the eye drops providing evidence that both these medicines were out of stock for a number of days since 29 November 2021.'*

The panel noted that Ms Lea had told Witness 1 directly that these medications were out of stock on 29 November 2021 and had been for a number of days. The panel considered that Ms Lea had an overarching responsibility as the registered Home Manager to ensure that required medications were in stock at all times.

Accordingly, the panel found this charge proved.

Charge 16.a.iii.

16. In respect of Service User T, failed to ensure that:
    a. Medication was given as prescribed, in that:
        iii. On 6 December 2021, the patient's MAR chart did not include Bioxtra gel and/or Viscotears,

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 whose CQC statement states:

‘When I examined the MAR charts dated 6 December 2021 neither medicine was listed and I saw there was no stock of either medicine in the home. I asked Karen Lea if they were still prescribed and she told me she didn't know and would have to find out.[…] ’

The panel noted the oral evidence of Witness 1, specifically that the MAR charts were created and printed by the dispensing pharmacist, it also noted that SUT’s GP would be responsible for prescribing SUT’s medications. The panel considered that the NMC had not provided any further information to support the assertion in the charge, that Ms Lea would be responsible for including SUT’s medication on their MAR chart. In the absence of such information, the panel was not satisfied that Ms Lea had a duty to ensure the medications specified in the charge were included on SUT’s MAR chart and therefore, she could not fail to ensure this.

Accordingly, this charge is found not proved.

Charge 16.a.iv.

16. In respect of Service User T, failed to ensure that:
    a. Medication was given as prescribed, in that:

    iv. Between 15 and 18 December 2021, medicine was omitted from the patient’s 24-hour syringe driver,

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1,

The panel noted Witness 1’s CQC statement that states:

‘I saw that on 6 October 2021 the GP […] issued a PMAC [Patient Medicines Administration Chart] for Sub Cut [Subcutaneous] Palliative care medicines via syringe driver over 24 hours for the following end of life medicines via syringe driver as recommended by the palliative care team:

I. Morphine Sulphate 10mg-20mg;

II. Midazolam 7.5mg - 60mg;

III. Levomepromazine 6.25-50mg and;

IV. Hyoscine Butylbromide 60mg- 120mg.

I examined the records of administration for the syringe driver (15 – 18 December 2021) and saw that only three of the four end of life medicines prescribed had been used in the syringe driver; Morphine 10mg/ml, Midazolam 10mg/2ml, Hyoscine Butylbromide. I asked the nurse on duty, Karen Lea why the Levomepromazine had not been included in the syringe driver. She told me that initially the district nurses had been administering the medicines via the syringe driver until the nurses in the home felt confident to administer the medicines this way. She told me that the district nurses had not included the Levomepromazine in the syringe driver so the nurses in the Location had not done so. […] During the inspection she made a call to the Palliative care team who told me that the Levomepromazine was to be used when required and that the service user had not required it. The palliative care team confirmed that the Levomepromazine had not initially been prescribed PRN and they understood there was a discrepancy and the directions were not as clear as they should be as they led to confusion.'

The panel had regard to Witness 1's oral evidence, it noted that when Witness 1 was asked about the correspondence between the GP and the palliative care nurses in respect of SUT's end of life medications, she told the panel that it was a '*very complicated trail of paperwork and correspondence'*. The panel also considered that there had been various professionals involved in the direct care of SUT regarding their end-of-life medications. In light of the lack of clarity about whether the Levomepromazine should have been administered and who was responsible for this decision, the panel was unable to establish that it was Ms Lea specifically who had failed to ensure that SUT's medication was given as prescribed, in that, between 15 and 18 December 2021, medicine was omitted from the patient's 24-hour syringe driver. Accordingly, this charge is found not proved.

Charge 16.v.

16. In respect of Service User T, failed to ensure that:
    a. Medication was given as prescribed, in that:

        v. On 15 December 2021, Hyoscine was out of stock.

This charge is found proved.

In reaching this decision, the panel took into account a photograph of SUT's stock control sheet dated 15 December 2021, the document entitled 'CQC Response to factual accuracy comments Sandrock Nursing Home' and the evidence of Witness 1.

The panel noted Witness 1's CQC statement that states:

> *'On 16 December 2021, the nurse on duty, Staff member T, told me at 14:00 hours that SUT was prescribed end of life medicines via a syringe driver but one of the medicines, Hyoscine, was out of stock. […] I looked at the stock control sheet in place for the end of life medicines and saw that the running balance was recorded on the sheet that the stock the previous day 15 December 2021 was recorded as a zero balance. […]'*

The panel also had regard to SUT's stock control sheet and it noted that Hyoscine had been recorded as having a '0' balance on 15 December 2021. The panel also noted the Home Owner's response to this incident included in the CQC Response to factual accuracy comments Sandrock Nursing Home which states:

> *'The medication had been ordered and the RGN on duty had phoned the chemist that morning and the medication would be delivered that afternoon. The medication in question is anti-sickness medication and can last in the body for up to 8 hours according to their half life.'*

In all the circumstances, the panel was satisfied that Ms Lea had failed to ensure that SUT's Hyoscine medication was given as prescribed in that it was out of stock on 15 December 2021. The panel considered that Ms Lea had overarching responsibility as the registered Home Manager to ensure that required medications were in stock at all times.

Accordingly, this charge is found proved.

Charge 16.a.vi.

16. In respect of Service User T, failed to ensure that:
    a. Medication was given as prescribed, in that:

    vi. On 15 December 2021, the patient did not receive medication for at least 1 hour.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC statement that states:

> *'[…] Although only the Hyoscine was out of stock, SUT could not have any of their prescribed end of life medicines because the syringe driver must be set up with all their medicines, which meant they were without their medicines for symptom control for an unknown period of time but for at least an hour. This means they may have unnecessarily experienced pain, sickness and terminal restlessness because the system for ordering medicines was ineffective.'*

The panel was of the view that Witness 1 had been a direct witness to this incident and that her oral evidence was consistent with her CQC statement. The panel was of the view that Ms Lea, as the Registered Manager of the Home and an experienced registered nurse, should of have had oversight of SUT's end of life medications. Further, to ensure that these medications which included pain control, were prioritised.

In all the circumstances, the panel found that Ms Lea had failed to ensure that SUT's medication was given as prescribed, in that, on 15 December 2021, the patient did not receive medication for at least 1 hour.

Accordingly, the panel found this charge proved.

Charge 16.b.

16. In respect of Service User T, failed to ensure that:
    b. PRN protocols were put in place for medicines contained in the patient's hospital discharge letter of 30 November 2021.

This charge is found proved.

In reaching this decision, the panel took into account SUT's discharge letter dated 30 September 2021 and the evidence of Witness 1.

The panel noted Witness 1's CQC statement that states:

'I examined the discharge information for SUT and saw that they were admitted to hospital on 22 September 2021 and discharged on 30 September 2021 to be managed by palliative care in the community.[…] The discharge letter listed the following medicines;

I. Glycopyrronium 200mg / 1ml 200mg 6 times daily, PRN for excessive secretions, - sub cut via syringe driver

II. Hyoscine 20mg/ml PRN 60mg over 24 hours for excessive secretions - sub cut via syringe driver

III. Levomepromazine 25mg/ml 6.25 sub cut four times daily PRN for nausea and vomiting

IV. Midazolam 10mg/2ml 2.5mg sub cut 6 x daily, PRN for agitation and 7.5mg subcut over 24 hours

V. Morphine 10mg/ml 2.5mg sub cut 6 times daily ,PRN pain and breathlessness AND 10mg sub cut via infusion over 24 hours

VI. Morphine Sulpahte (10mg/5mls) oral solution 5mg six times daily PRN for pain

VII. Nystatin 100,000 units /ml 1ml for 2 days four times daily

VIII. Viscotears 1 drop both eyes when needed PRN for dry eyes

IX. Bioxtra dry mouth gel to be given FOUR times daily

I saw there were no protocols in place to ensure the safe administration of these "when required" medicines. The registered manager confirmed there were no PRN protocols for these medicines and there was no clear guidance for nurses to administer the end of life medicines safely. After the inspection the manager confirmed that she had spoken with the GP and the Levomepromazine was removed from the medicines that were prescribed to be administered every 24 hours but remained as a PRN medicine however no PRN protocol was submitted to the Commission.'

The panel had regard to SUT's discharge letter and noted that it supported the evidence of Witness 1, in that all the medications listed in her written statement were listed on the letter. In addition, the panel was not provided with any evidence of PRN protocols. In the absence of such information, the panel accepted the evidence of Witness 1 as it was of the view that it was consistent and credible. The panel determined that Ms Lea as the registered Home Manager had a responsibility to ensure that PRN protocols were put in place for medications that required it.

Accordingly, the panel found this charge proved.

Charge 16.c.i.

16. In respect of Service User T, failed to ensure that:

c. Accurate records of medication were kept, in that:

i. Between 1 October and 8 October 2021, Morphine Sulphate 10mg/ml went unaccounted for.

This charge is found proved.

In reaching this decision, the panel took into account a photograph of SUT's CD register and Witness 1's evidence.

The panel noted Witness 1's CQC statement that states:

> *'I found that [Ms Lea and the Registered Provider] also failed to keep accurate and legal records of Controlled Drugs. I examined the Controlled Drug Register and found that nurses failed to keep legally required records of the use of Morphine Sulphate 10mg/ml ampoules for SUT in the Controlled Drug Register as laid down by The Misuse of Drugs Act 1971. […] Page 11 of the Controlled Drug Register shows that 20 Ampoules Morphine Sulphate 10mg/ml were recorded as received from APH, but the date of receipt was not recorded. On the 30 September 2021 and 1 October 2021, the records show that one ampoule was used each day and the balance was 18 Ampoules. The next line stated, "Updated from 7/10/21", the next entry was on 7 October 2021 stating that another ampoule had been given and the balance was 12 ampoules.'*

In her oral evidence, Witness 1 confirmed that the Home had a legal obligation to record the date, time and amount of controlled drugs which were administered to SUT. The panel had sight of SUT's CD record between 1 October and 8 October 2021 and noted that six Morphine Sulphate 10mg/ml ampoules were unaccounted for in the records. The panel accepted that Ms Lea did have a duty to ensure that accurate records of medication were kept in respect of SUT and she failed to ensure that these records were accurate.

Accordingly, this charge is found proved.

Charge 16.c.ii.

16. In respect of Service User T, failed to ensure that:
    c. Accurate records of medication were kept, in that:
        ii. The controlled drugs register did not show times of administration.

This charge is found proved.

In reaching this decision, the panel took into account a photograph of SUT's controlled drug record and Witness 1's written evidence.

The panel noted Witness 1's CQC statement that states:

> *'[…] the nurses recorded the use of Morphine and the other medicines in the syringe driver in the Controlled Drug Register, but the register did not have a column for the time of administration so it was not possible to evidence that the medicines had been given over the correct time interval (24 hours).*'

The panel had regard to the photograph of SUT's controlled drug record and noted that there was no time recorded for the administration. The panel considered that this was consistent with the evidence of Witness 1 and accepted her evidence. The panel determined that Ms Lea had failed to ensure that accurate records were kept, in that, SUT's controlled drugs register did not show times of administration.

Accordingly, the panel found this charge proved.

Charge 16.c.iii.

16. In respect of Service User T, failed to ensure that:
    c. Accurate records of medication were kept, in that:
        iii. The syringe driver was not labelled to show the time the driving started.

This charge is found NOT proved.

In reaching this decision, the panel took into account a photograph of SUT's record of administration for their 24-hour syringe driver and Witness 1's evidence.

The panel noted Witness 1's CQC statement that states:

> *'Good practice guidance for the syringe driver state that all syringes containing drug additive must be labelled and it should include the patients name, the date and time of preparation, the name and dose of all drugs and the name of the diluents plus the initials of the person preparing it. I looked at SUT syringe driver and found that there was no such label on the syringe that had run out or on the new syringe placed into the driver on 16 December 2021.'*

The panel had regard to SUT's record of administration for the 24-hour syringe driver and it noted that Ms Lea had not been the nurse administering the medication, however, it acknowledged that she had signed that she had witnessed the preparation of the medications. The panel was of the view it was the responsibility of the nurse administering the medication to label the time the syringe driver was started. In the absence of further evidence to support the assertion in the charge, the panel concluded that although Ms Lea as the Registered Manager was accountable for the overall responsibility for ensuring accurate records of medicines administration, she should not be held accountable for this isolated incident.

Accordingly, the panel determined that this charge is found not proved.

Charge 16.d.i.

16. In respect of Service User T, failed to ensure that:
    d. Care plans were adequate, in that:
        i. The consent plan included contradictory evidence relating to the patient's capacity.

This charge is found NOT proved.

The panel was not provided with SUT's care plan, nor was there any written or oral evidence from any of the witnesses in relation to this charge. The panel bore in mind that the burden of proof rests upon the NMC and that no evidence had been provided to support the assertion in the charge.

Accordingly, the panel determined that this charge is found not proved.

Charge 16.d.ii.

16. In respect of Service User T, failed to ensure that:
    d. Care plans were adequate, in that:
        ii. The COVID-19 risk assessment was not specific to the patient.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2.

The panel noted Witness 2's CQC witness statement that states:

> *'I looked at the COVD-19 risk assessments and management plans in place for persons SUM, SUW SUT and SUB. I found them to be extremely limited, generic and meaningless. They did not adhere to the advice set by the Government in respect of ensuring people's individual risks, needs and vulnerabilities being assessed and managed*.'

The panel was not provided with SUT's COVID-19 risk assessment. The panel bore in mind that the burden of proof rests upon the NMC and that no evidence had been provided to support the assertion in the charge.

Accordingly, the panel determined that this charge is found not proved.

Charge 17.

17. In respect of Service User U, in December 2021, failed to ensure that they had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted that Witness 1's CQC witness statement states:

> *'At this inspection, I found that [Ms Lea and the Registered Provider] had also failed to put a system in place to ensure that service users allergy status was recorded. This is an ongoing concern from the inspection in May 2021. I examined the MARS sheets and Meds Profiles for 13 service users and saw that allergy status section was not completed for six service users. SUN, SUU, SUM, SUV, SUP and SUF. It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to.'*

The panel was not provided with any documentation in respect of Service User U ('SUU'). However, the panel noted that Witness 1's evidence regarding service users' allergy statuses had been credible and consistent. Witness 1 had reiterated in her oral evidence that SUU did not have any up-to-date allergy status recorded in their notes. The panel accepted the evidence of Witness 1, and agreed that SUU had been put at risk in the absence of this important information. The panel was therefore satisfied that Ms Lea had failed to ensure in December 2021 that SUU had an up-to-date allergy status in their notes.

Accordingly, the panel determined that this charge is found proved.

Charge 18. a.

18. In respect of Service User V, failed to ensure that:
    a. Between 14 and 21 December 2021, the patient received their prescribed Sertraline 50mg.

This charge is found proved.

In reaching this decision the panel took into account the evidence of Witness 1 and Service User V's ('SUV') interim MAR charts dated 16 November 2021 and 20 December 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'[…] I examined SUV's interim MAR chart dated 16 November 2021 and saw they had been prescribed Sertraline 50mg; one to be taken daily […] On 14 December 2021 the nurses recorded as zero balance and annotated the MARS with the word "requested".'*

The panel had regard to this MAR chart and noted that Witness 1's evidence was supported by this document, in that a zero balance was recorded for 14 December 2021.

Witness 1's CQC witness statement also states:

> *'[…] On 16 December 2021 the nurse of [sic] duty Staff Member T confirmed that the medicine was out of stock even though they had ordered it on Tuesday (14 December 2021), and they had missed two doses.'*
>
> *'On 20 December 2021 I saw that the MAR chart had been signed to show that Sertraline had been given on 18 and 19 December in the morning but it had not been signed for on 20 December 2021. There was no record any stock had arrived. I looked in the trolley but could not find any stock. I asked Staff Member*

M a nurse if the medicine was in stock and they said they were unsure. I asked the [sic] Karen Lea and she told me that the medicine had not yet been received and was still out of stock.

[….]

I asked why it had been signed for on 18 and 19 December 2021 and she told me that the nurse had made an error in signing for the medicines on those days because there was no stock. […] After the inspection visit we asked the registered manager to tell us when the medicine was received and she stated "The chemist was contacted on the Monday 20 December to follow up and the sertraline had been placed in with the monthly repeats by mistake it was received late on the Tuesday 21 -The first dose was given Wednesday am".'

Witness 1 had explained in both her oral evidence and her statement that Ms Lea had confirmed the medication was given on Wednesday 22 December 2021 when it arrived in stock, meaning SUV had not received their prescribed Sertraline 50mg since 14 December 2021. The panel noted that despite this, SUV's interim MAR chart dated 16 December 2021 had been signed as administered on 18 and 19 December 2021. The panel found that Witness 1's evidence was consistent with all of the documentary evidence before it in respect of this charge.

Accordingly, the panel determined that this charge is found proved.

Charge 18. b.

18. In respect of Service User V, failed to ensure that:
    b. In December 2021, the patient had an up-to-date allergy status in their notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and SUV's MAR chart dated 16 November 2021.

The panel noted Witness 1's CQC witness statement that states:

> *'At this inspection, I found that [Ms Lea and the Registered Provider] had also failed to put a system in place to ensure that service users allergy status was recorded. This is an ongoing concern from the inspection in May 2021. I examined the MARS sheets and Meds Profiles for 13 service users and saw that allergy status section was not completed for six service users. SUN, SUU, SUM, SUV, SUP and SUF. It is important that this information is on the MAR charts so that staff giving medicines can check the allergy status immediately prior to administering medicines. This meant that all six service users were put at risk of being given medicines they were allergic to.'*

The panel noted that on this record the allergy section was incomplete. The panel determined that Witness 1's written evidence was consistent with her oral evidence. The panel accepted the evidence of Witness 1, and it was of the view that SUV had been put at risk in the absence of this important information. The panel was therefore satisfied that Ms Lea had failed to ensure in December 2021 that SUV had an up-to-date allergy status in their notes.

Accordingly, the panel determined that this charge is found proved.

Charge 19. a.

19. In respect of Service User W, failed to ensure that:
    a. The patient was not deprived of their personal possessions.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and Ms Lea's appeal statement in response to the CQC's Notice of Proposal, dated 4 April 2021.

The panel noted Witness 2's CQC witness statement that states:

> *'During the previous April 2021 inspection, I observed SUW continually ask staff for their wallet. I observed SUW becoming distressed at not having [their] wallet in [their] possession. I saw and heard staff continually distract SUW from obtaining his wallet by asking [them] to come back later or by re-directing [them] to the lounge for a cup of tea. I checked SUW's care file in April 2021 to see if they had consented to this practice. No evidence could be found.'*
>
> *Karen Lea confirmed that SUW had capacity. I asked [Ms Lea] that, if SUW had capacity, why [were they] being deprived of [their] wallet. Karen Lea was unable to give a satisfactory explanation. I asked her to review this practice immediately.'*

It also states:

> *'At the December 2021 inspection, I found the same practice was still being adopted. I once again observed SUW continually present [themselves] in the general office or Karen Lea's office looking for and requesting [their] wallet. I observed SUW becoming more and more distressed and agitated. Once again, staff re-directed [them] to come back later or to the lounge for a cup of tea, only for SUW to present again shortly afterwards requesting [their] wallet again.'*
>
> *'[…] I asked [Ms Lea] why SUW's wallet was still excluded from his possession when it was clear that [they were] visibly distressed by this practice. Karen Lea replied that SUW's wallet was removed from [their] possession, as "[they were] leaving it in [their] trouser pocket and laundry staff kept forgetting to check and*

kept putting it in the washing machine". I explained to her that it was not a reasonable or acceptable explanation for depriving SUW of [their] own wallet.'

During Witness 2's oral evidence she described this incident as '*distressing*'. She explained that when she discussed the issue with Ms Lea, she did not seem to grasp the concept that she was denying Service User W ('SUW') a basic human right. Ms Lea demonstrated no understanding that it was unreasonable to deprive SUW of his wallet.

The panel then took into account Ms Lea's appeal statement that states:

'The comment in relation to the person who was deprived of a personal possession is to do with a service user's wallet. [Their] credit card had been mistakenly put in the wash on three occasions. […] This was also discussed with their daughter who agreed this would be in this person's best interest. Although I did not record this information anywhere, I have the text messages with his daughter confirming she was happy with this practise […].'

The panel noted that Ms Lea had not provided any record of SUW's daughter confirming that she was content with this practice. Therefore, there was no documentary evidence to support this assertion. In addition, the panel determined that as SUW was deemed to have capacity and was clearly agitated about not having access to their wallet any agreement with his daughter should have been reviewed. Despite being advised in April 2021 to review this practice, Ms Lea had taken no action by the time the second inspection took place in December 2021. The panel concluded that SUW was deprived of their personal possessions.

Accordingly, the panel determined that this charge is found proved on a balance of probabilities.

Charge 19. b.

19. In respect of Service User W, failed to ensure that:

b. An investigation took place following the patient's discharge from hospital on 5 January 2021.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUW's hospital discharge summary dated 5 January 2021.

The panel noted Witness 2's CQC witness statement that states:

> '*I looked at the accident and incident records for SUW. I saw that on the 03 January 2021, SUW had been found on the floor, lying outside of his bedroom. The accident and incident record documented that SUW "claimed another resident had pushed him over". SUW was taken to the Accident and Emergency department […] the next day having sustained several injuries.'*

The panel noted that SUW's discharge summary confirmed that he was admitted to hospital on 4 January 2021, and that it states: '*patient found in nursing home lying on the floor, reportedly pushed by neighbour'.* The panel also had regard to an entry on 3 January 2021 in the Home's Incident and Accident Book that states:

> *'Staff heard a bang from upstairs and on investigation SUW was lying outside his room, he claimed another resident pushed him over'*

The panel noted that this documentary evidence was consistent, in that SUW reported that he had been pushed over.

Witness 2's CQC statement also states:

> '*Despite this, there was no evidence that [Ms Lea and the Registered Provider] had investigated this incident nor had taken steps to protect SUW and other people living in the home from further potential harm […] I asked Karen Lea on 20 December 2021 for a copy of the incident investigation report into SUW's fall*

and the allegation of abuse [.] She was unable to provide a copy of this report to document that an investigation had taken place […]'

The panel was of the view that Witness 2's evidence had been consistent with the documentary evidence before it and in the absence of any further evidence to undermine Witness 2's findings, the panel accepted the evidence of Witness 2. The panel concluded that no investigation had taken place into this incident following SUW's discharge from hospital on 5 January 2021.

Accordingly, the panel determined that this charge is found proved.

Charge 19. c.

19. In respect of Service User W, failed to ensure that:
    c. Sufficient temperature checks were taken, in that, between 1 April and 16 December 2021, temperature checks were only taken on 6 occasions.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUV's temperature check records dated from 1 April and 16 December 2021.

The panel noted Witness 2's CQC witness statement that states:

'The Government guidelines at the time of both inspection in April and December 2021 clearly advised health and social care providers to ensure that people living in a care home had a COVID-19 PCR test every 28 days and their temperature checked twice a day. Yet despite this, [Ms Lea and the Registered Provider] had not ensured that these checks were made. For example, I checked SUB's and SUW's care file for evidence a PCR test had been taken every 28 days and that their temperature had been monitored twice a day. I found these checks had not been completed.'

It also states:

> *'SUW's temperature was only taken on 28 April 2021, 17 June 2021 and August 2021. There was no temperature monitoring for May, July and September 2021 to show that SUW's temperature had been taken and monitored at the time during these months. In November 2021, SUW's temperature was taken once on 17 November and twice on 24 November 2021 within 30 minutes of each other. SUW's temperature was not monitored and record again until 14 December 2021'.*

The panel had regard to SUW's temperature check records, noting that there were only six recordings between 1 April and 16 December 2021 and that this was consistent with Witness 2's evidence. The panel also noted the COVID-19 guidelines at the material time were that temperatures were required to be taken and monitored twice a day. The panel concluded that Ms Lea had failed in respect of SUW, to ensure that sufficient temperature checks were taken between 1 April and 16 December 2021.

Accordingly, the panel determined that this charge is found proved.

Charge 19. d. i.

19. In respect of Service User W, failed to ensure that:
    d. Care plans were adequate, in that:
        i. The consent plan included contradictory evidence relating to the patient's capacity.

This charge is found NOT proved.

The panel was not provided with SUW's care plan, nor was there any written or oral evidence from any of the witnesses in relation to this charge. The panel bore in mind that the burden of proof rests upon the NMC and that no evidence had been provided to support the assertion in the charge.

Accordingly, the panel determined that this charge is found not proved.

Charge 19. d. ii.

19. In respect of Service User W, failed to ensure that:
    d. Care plans were adequate, in that:
        ii. The COVID-19 risk assessment was not specific to the patient.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and SUW's COVID-19 risk assessment, last update 22 November 2021.

The panel noted Witness 2's CQC witness statement that states:

> *'I looked at the COVD-19 risk assessments and management plans in place for persons SUM, SUW SUT and SUB. I found them to be extremely limited, generic and meaningless. They did not adhere to the advice set by the Government in respect of ensuring people's individual risks, needs and vulnerabilities being assessed and managed*.'

The panel had regard to SUW's COVID-19 risk assessment and it was of the view that this assessment was not patient specific. It was almost identical to those of other service users, including generic statements such as *'[…] is over 70 and is classed as vulnerable and high risk'* and it did not outline any specific patient needs or health concerns. In addition, the agreed actions were identical.

Accordingly, the panel determined that this charge is found proved.

Charge 20.

20. Failed to ensure that one or more of the following medicines were stored with dispensing labels:

a. Lantus Solostar insulin pens,
b. Oral chemotherapy pack,
c. Daktacort,
d. Daktarin,
e. Olive oil ear drops.

These charges are found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and exhibited photographs of the medications set out in the charges.

The panel noted Witness 1's CQC witness statement that states:

> *'I found [Ms Lea and the Registered Provider] had failed to ensure there was a system in place to ensure that all medicines were labelled. I saw that there were a number of medicines which did not have a dispensing label. I saw that Lantus Solostar insulin pens, oral chemotherapy pack in the medicines trolley, a tube of Daktacort and Daktarin in the stock cupboard and some Olive Oil ear drops in current use were all unlabelled.'*

The panel noted that the photographic evidence before it supported the written and oral evidence of Witness 1, in that all of the medicines were unlabelled. The panel concluded that this could put service users at risk of cross-contamination if it was unclear who the medication was prescribed for.

Accordingly, the panel determined that this charge is found proved.

Charge 21. a.

21. Failed to ensure that medication was stored appropriately, in that:
    a. The medicine fridge was unclean.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and an exhibited photograph showing the interior of the medicine fridge.

The panel noted Witness 1's CQC witness statement that states:

> '*I also saw that medicines in the fridge were also stored unhygienically, the fridge was dirty as there were spills which had not been cleaned and there was grime and a tablet stuck in the door seal of the fridge. If medicines are stored in dirty conditions, it poses an infection risk.'*

The panel had regard to this photograph and noted that it clearly evidenced that the fridge was unclean, and that there was a loose tablet stuck in the door seal.

Accordingly, the panel determined that this charge is found proved.

Charge 21. b.

21. Failed to ensure that medication was stored appropriately, in that:
    b. There was no key for the medicine fridge.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1.

The panel noted Witness 1's CQC witness statement that states:

> *'I asked Staff Member S for the key for the fridge, they told me that the fridge was not locked because no key could be found to lock it.'*

The panel noted that there was no key to the medicine fridge at the time of the April CQC inspection and accepted that a staff member had told Witness 1 this during the

inspection. In the absence of any contradictory evidence, the panel concluded that medication was not stored appropriately.

Accordingly, the panel determined that this charge is found proved.

Charge 21. c.

21. Failed to ensure that medication was stored appropriately, in that:
    c. Waste medicine was not kept in locked cupboards.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the NICE guidance entitled '*Managing medicines in care homes'* ('the NICE guidance') published 14 March 2014.

The panel noted Witness 1's CQC witness statement that states:

> *'I also noted that waste medicines were not stored in line with current NICE guidance which state "Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy". I saw that the waste medicines were stored in a non-tamper-proof container on the floor of the medicines room and not in a locked cupboard. If medicines are not stored safely, they could be misappropriated or misused, placing service users at risk of harm.*'

The panel then took into account the NICE guidance that states:

> ***'1.12 Receiving, storing and disposing of medicines***
>
> *[…]*

1.12.6 Care home providers should keep records of medicines (including controlled drugs) that have been disposed of or are waiting for disposal. Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy.'

The panel had regard to the wording of the charge, and it noted that the NICE guidance did not explicitly state that medication was required to be locked in a cupboard, despite Witness 1 stating this in her written statement. In the absence of any other evidence to support the assertion in the charge, the panel were unable to establish a duty for the waste medicines to be kept in a locked cupboard.

Accordingly, the panel determined that this charge is found not proved.

Charge 22.

22. In May 2021, failed to ensure sufficient Paracetamol was in stock.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and an exhibited photograph of a box of Paracetamol labelled 'domestic remedy.'

'During the inspection I found a box of soluble Paracetamol which bore a handwritten label stating "DOMESTIC REMEDY". I noticed that a dispensing label had been torn off the box and the patient's name was just visible on the box. Once a medicine is dispensed for a Service User it becomes the property of that Service User and must not be reused by anyone else.'

The panel was not provided with any evidence pertaining to the expected stock levels of Paracetamol in the Home at the time and noted that this charge was not in respect of a specific service user. In the absence of evidence to support that the Home had an insufficient amount of Paracetamol in stock, the panel found this charge not proved.

Charge 23

23. Failed to adhere to government guidelines on COVID 19.

The panel first considered whether there was a duty upon Ms Lea to adhere to government guidelines on COVID-19. The panel noted the guidance exhibited by Witness 2, namely, 'COVID-19 Adult Social Care Risk Reduction Framework' updated 1 December 2020. Having regard to this guidance, the panel was of the view that it did establish an overarching duty on Ms Lea, as the Registered Manager of the Home to adhere to this guidance on COVID-19 and a duty to oversee her staff's adherence to the guidance. The panel then considered charges 23.a.-c.

Charge 23.a.

23. Failed to adhere to government guidelines on COVID 19, in that:
    a. A staff testing spreadsheet was not set up until July 2021.

This charge is found proved.

In reaching this decision, the panel observed the Home's COVID-19 staff testing spreadsheet and took into account the evidence of Witness 2.

The panel noted Witness 2's CQC statement:

> *'I found that, since the last inspection, records in relation to staff testing were still not properly maintained. Firstly, the spreadsheet to record staff testing and their outcomes had not been set up till July 2021, three months after the issue was identified.[…]*

The panel noted that week 1 of the COVID-19 staff testing spreadsheet was '*05/07/2021'*, which was consistent with the evidence of Witness 2. The panel accepted the evidence of Witness 2, who had been present at the material time and viewed this document. The panel also considered that Ms Lea was reminded about the requirement

to *'follow DHSC* [Department of Health and Social Care] *and PHE* [Public Health England] *advice on testing'* by Witness 2 in the April 2021 inspection. The panel was not provided with any further COVID-19 staff testing spreadsheet pertaining to earlier dates prior to July 2021, nor did Ms Lea provide any other evidence to the panel with regards to this charge. In the absence of such evidence, the panel found this charge proved.

Charge 23.b.

23. Failed to adhere to government guidelines on COVID 19, in that:
    b. Staff had gaps on the testing spreadsheet.

This charge is found proved.

In reaching this decision, the panel took into account the Home's COVID-19 staff testing spreadsheet and the evidence of Witness 2. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel noted Witness 2's CQC statement:

> '*I saw that there were 40 staff members listed on [Ms Lea's] testing spreadsheet, with multiple gaps in the testing of staff members for COVID-19 purposes.[…]*
>
> *The multiple gaps in [Ms Lea's and the Provider's] staff testing spreadsheet clearly showed that COVID-19 staff testing guidelines set by the government were not and had not been followed since the last inspection in April 2021'*

The panel had regard to the spreadsheet and noted that the requirement was for weekly PCR tests. Some gaps were accounted for due to annual leave or sickness, but the panel noted that Witness 2's written evidence was consistent with its own assessment of this document, in that there were multiple gaps on the spreadsheet with no reason documented for these gaps. Accordingly, the panel found this charge proved.

Charge 23.c. and 23.d.

23. Failed to adhere to government guidelines on COVID 19, in that:
    c. Staff had not competed weekly PCR tests,
    d. Staff had not competed weekly LFT tests.

These charges are found proved.

In reaching this decision, the panel took into account the Home's COVID-19 staff testing spreadsheet and the evidence of Witness 2. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel noted Witness 2's CQC statement:

> '[…] *during the week commencing the 08 November 2021:*
>
> *a) 15 staff members had not completed the required weekly PCR test. The PCR test results for three members had also not been obtained and recorded;*
> *b) 27 staff members had not completed the two weekly LFT tests; and*
> *c) One of the LFT tests results for three staff members had not been obtained and recorded.'*

The panel had regard to the spreadsheet, noting that the spreadsheet provided was dated from 5 July 2021 to 18 November 2021, including the week referred to in Witness 2's written evidence. The panel noted witness 2's evidence was consistent with its findings and that the spreadsheet did support her evidence above. The panel noted that no explanation was provided for a number of the gaps, or incomplete LFT and PCR tests. Accordingly, the panel found these charges proved.

Charge 24

24. Failed to ensure all patient bedrooms were deep cleaned.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and the Home's Deep Cleaning record dated November to December 2021. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel first considered whether there was a duty upon Ms Lea to adhere to government guidelines on COVID-19 in relation to deep cleaning. The panel noted the guidance exhibited by Witness 2, namely, COVID-19: Guidance for maintaining services within health and care settings (published June 2021). This guidance states:

> *'The IPC [Infection Prevention and Control] principles in this document apply to all health and care settings, including […] care homes.'*

Having regard to this guidance, the panel was of the view that it did establish an overarching duty on Ms Lea as the Registered Home Manager, to ensure cleaning frequencies and standards were adhered to at the material time in all areas of the Home.

The panel noted Witness 2's CQC statement:

> *'I looked at the deep cleaning records provided by [Ms Lea and the Registered Provider]. I found major gaps in what bedrooms had and had not been deep cleaned. For example, in November 2021, there were over 20 people living in the home but only 11 bedrooms had been deep cleaned. There was no evidence of any daily cleaning in respect of any individual bedrooms.[…]*
>
> *There were also no records to show that communal areas, shared equipment and frequently touched surfaces such as light switches and door handles, were cleaned in accordance with government guidance in order to prevent the spread of infection.'*

The panel noted that Witness 2's written statement was also consistent with her oral evidence. It had regard to the Deep Cleaning records exhibited by Witness 2, noting that not all areas included on the check lists to be cleaned had been recorded as completed. Further, the panel noted that the number of checklists provided did not reflect the number of occupied rooms in the Home at the material time.

Accordingly, the panel found this charge proved.

Charge 25

25. Failed to maintain proper staff training standards.

The panel first considered whether there was a duty upon Ms Lea to maintain proper staff training standards. The panel noted CQC guidance exhibited by Witness 2, titled 'Guidance for providers on meeting the regulations Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended)'. This guidance states:

> *'Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.*
>
> - *Training, learning and development needs of individual staff members must be carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role.*
> - *Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised.*
> - *Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.*
> - *Staff should be supported to make sure they are can [sic] participate in:*
>   - *Statutory training.*

- *Other mandatory training, as defined by the provider for their role.*
- *Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.*
- *Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.*

- *All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.*
- *Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.'*

Having taken this guidance into account and regulation 18 (2)(a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the panel found that Ms Lea, as the Registered Home Manager did have a duty to maintain proper staff training standards. The panel then considered charges 25.a.-e.

Charge 25.a.

25. Failed to maintain proper staff training standards, in that not all staff:
    a. Completed their training.

This charge is found proved.

In reaching this decision, the panel took into account the Home's training matrix dated 1 September 2021 and the evidence of Witness 2. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel noted Witness 2's CQC statement that states:

'During the last inspection in April 2021, I found that the Appellants had not ensured that staff training was sufficient or up to date to ensure that staff had the skills and knowledge to provide effective care. During the inspection carried out in December 2021 I found the same.

I looked at staff training matrix and saw that some improvements to the completion of staff training had been made, but 65% of the staff team had still not completed or refreshed all of their training in accordance with the provider's mandatory training programme. I attach as Exhibit KC/61 the Staff Training Matrix. The appellant's staff training records showed that, for example:

a. *Six staff had not completed or refreshed fire safety training:*
b. *Five staff had not completed or refreshed moving and handling training;*
c. *Five staff had not completed or refreshed first aid training;*
d. *Six staff had not completed or refreshed health and safety training;*
e. *Four staff had not completed training in how to respond to behaviours that challenge and;*
f. *Seven staff had not completed or refreshed training in the Deprivation of liberty safeguards.'*

The panel had regard to the Home's training matrix and noted that its assessment of this chart was consistent with the findings of Witness 2, in that not all members of staff had completed their training.

Accordingly, the panel found this charge proved.

Charge 25.b.

25. Failed to maintain proper staff training standards, in that not all staff:
    b. Were included on the staff training matrix.

This charge is found proved.

In reaching this decision, the panel took into account the Home's training matrix dated 1 September 2021 and the evidence of Witness 2. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel noted Witness 2's CQC statement states:

> *'I also found that two staff members, S04 and S05 were not on the training matrix at all. Yet, [Ms Lea's] COVID-19 testing records showed that they had been working in the home since at least August 2021. This meant that there was no record on the training matrix to show that either staff member had completed any training for their job role.'*

The panel noted that 38 members of staff had been listed on the training matrix dated 1 September 2021 and the COVID-19 staff testing spreadsheet listed from 27 September 2021 listed 41 members of staff. The panel found that its findings was consistent with the evidence of Witness 2, in that not all staff were included on the training matrix. Accordingly, this charge is found proved.

Charge 25.c., 25.d. and 25.e.

25. Failed to maintain proper staff training standards, in that not all staff:
    c. Received appraisals,
    d. Were assessed on skills and/or competencies,
    e. Received inductions and/or supervision.

This charge is found NOT proved.

In reaching this decision, the panel took into account the Staff Supervision and Appraisal Matrix and the written evidence of Witness 2.

The panel noted Witness 2's CQC statement that states:

‘I looked at staff Supervision and Appraisal Records. I saw there was no record of any staff member receiving an appraisal during the last 12 months. This meant there was no evidence that the skills, abilities and competencies of staff members had been reviewed and any training, learning and development needs identified, planned for and met. This also meant the Appellants could not be assured that staff members had maintained the necessary skills to meet the needs of the people they cared for and support. With regards to staff supervision records, I saw that staff members had received supervision from a newly appointed manager, S06 within the organisation.

I looked at the personnel file of S06 and found no evidence that the Appellants had appropriately assessed the skills and competencies of S06 to supervise both clinical and care staff in the workplace. This person was still in their probationary period. They had not completed any of the provider's mandatory training and had not received supervision themselves from the Appellants since they commenced in employment in October 2021.’

The panel noted that the Staff Supervision and Appraisal Records sheet was not dated but covered the months of July - December, and that there were no entries for any staff between July - September. However, with regards to charge 25.e, the panel had not been provided with any evidence relating to staff inductions. For charges 25.c and 25.d, the panel had not been provided with evidence relating to supervision or appraisals for the full 12 months period referred to by Witness 2.

Witness 2 asserted that Ms Lea could not have assessed the skills or competencies of the staff given that she found a lack of supervision and appraisal. However, the panel had not been provided with the evidence of the lack of appraisals or supervision for the 12-month period and therefore could not find charge 25.d proved.

Therefore, the panel determined that the NMC had not provided sufficient evidence for the panel to be able to find these charges proved.

Charge 26

26. Failed to maintain proper levels of staffing.

The panel first considered whether there was a duty upon Ms Lea to maintain proper levels of staffing. The panel noted CQC guidance exhibited by Witness 2, titled 'Guidance for providers on meeting the regulations Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended)'. This guidance states:

> *'Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).*
>
> - *Providers should have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. The approach they use must reflect current legislation and guidance where it is available. In determining the number of staff and range of skills required to meet people's needs, they should consider the different levels of skills and competence required to meet those needs, the registered professional and support workers needed, supervision needs and leadership requirements.*
>
> - *Staffing levels and skill mix must be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.'*

Having taken this guidance into account and regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the panel found that Ms Lea, as the Registered Home Manager did have a duty to maintain proper levels of staffing. The panel then considered charges 26.a and 26.b.

Charge 26.a.

26. Failed to maintain proper levels of staffing, in that:

a. No dependency tool and/or staffing level policy was in place for Sandrock Nursing Home.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and a Staff Policy document exhibited. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel noted Witness 2's CQC statement that states:

> '*Dependency tools can help providers to assess the number of staff required. These tools aim to collate information to assess the dependency of each individual requiring care and support and how many hours of staff support they need. I asked Karen Lea if they had a dependency tool in place to help them determine the number of staff and staff skills required to support people living in the home safely and effectively. The Appellant confirmed that a dependency tool was in place. I requested a copy of this tool and was given a copy of a Staffing Level policy for a different care home called Rodwell House by Karen Lea. This document was not a dependency tool pertaining to Sandrock Nursing Home.*
>
> *When I challenged the appellant about this, Karen Lea acknowledged that they did not have a dependency tool in place for Sandrock Nursing Home. They also acknowledged they did not follow the 'Staffing Level Policy' for Rodwell House. It was concerning that the Karen Lea had given me a document that they did not use and that did not relate to Sandrock Nursing Home. It was also concerning that they had not been open and transparent about not having a dependency tool in place when they were first asked.'*

The panel had regard to the Staffing Level Policy noting that it was titled 'Rodwell House', which was the policy of another care home, and that this was consistent with the evidence of Witness 2. In addition, the panel was not provided with a dependency tool in respect of the Home's staffing level and it noted that Ms Lea had told Witness 2

directly that there was not a dependency tool in place at the Home. The panel accepted the evidence of Witness 2. It found Witness 2's written evidence was consistent with her oral evidence and therefore found it to be credible. The panel concluded that without a dependency tool and staffing level policy Ms Lea would have been unable to maintain proper levels of staffing.

Accordingly, the panel determined that this charge is found proved.

Charge 26.b.

26. Failed to maintain proper levels of staffing, in that:

b. Between 15 November and 6 December 2021, staffing numbers were inconsistent when the same staffing level was required

This charge is found NOT proved.

In reaching this decision, the panel took into account the Home's staff rota dated 6-12 December 2021 and the evidence of Witness 2.

The panel noted Witness 2's CQC statement that states:

> *'I looked at the staff rotas for 15 November and 12 December 2021 and saw that staffing levels constantly fluctuated. The rotas showed that two or three days a week, the number of staff on duty was lower than other days with the same number of people to care for with the same level of need. For example, on 06 December 2021, four staff members worked 09:00 to 14:00, with three staff working 14:00 to 20:00. On 07 December only three staff members worked the 08:00 to 14:00 shift and two staff worked 14:00 to 20:00.[…] This drop in staffing numbers did not make sense. It was impossible to tell if staffing levels remained safe at these lower levels without a dependency tool or other system in place to show what safe staffing levels should be.'*

Whilst the panel accepted that Witness 2 viewed the rotas for the period specified in the charge, the panel was only provided with the rota pertaining to six days of this period. The panel was also of the view that when assessing staffing levels, the experience of staff members is also highly relevant, however, the panel did not have any information regarding the experience of those included in the rota. The panel bore in mind that the burden of proof rests upon the NMC and that the evidence provided did not support the assertion in the charge.

Whilst the panel accepted that Witness 2 viewed the rotas for the period specified in the charge, the panel was only provided with the rota pertaining to six days of this period. In response to panel questions, Witness 2 said that she did not consider the staffing levels on the rota to be unsafe. The panel considered that when assessing consistent staffing levels, in addition to the dependency level of residents, the experience of staff members is also highly relevant. If staff are more experienced, less staff may be required. However, the panel did not have any information regarding the experience of those included in the rota.

Consistency is important in relation to safety and Witness 2 did not consider the staffing levels to be unsafe. The panel bore in mind that the burden of proof rests upon the NMC and that the evidence provided did not support the assertion in the charge.

Therefore, on the balance of probabilities, the panel found this charge not proved.

Charge 27.

27. Failed to maintain adequate recruitment processes.

The panel first considered whether there was a duty upon Ms Lea to maintain adequate recruitment processes. The panel noted CQC guidance exhibited by Witness 2, titled ‘Guidance for providers on meeting the regulations Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended)’. This guidance states:

'Providers must have effective recruitment and selection procedures that comply with the requirements of this regulation and ensure that they make appropriate checks for both employees and directors.

- *Information about candidates set out in Schedule 3 of the regulations must be confirmed before they are employed.*
- *Other checks deemed appropriate by the providers may also be undertaken.'*

In light of this guidance, the panel found that Ms Lea, as the Registered Home Manager did have a duty to maintain adequate recruitment processes.

The panel then considered charges 27.a and 27.b.

Charge 27.a.

27. Failed to maintain adequate recruitment processes, in that:
    a. Insufficient effort was made to obtain references for 1 or more staff members.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and the exhibited references of two members of staff. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel noted Witness 2's CQC statement that states:

'At the April 2021 inspection, the provider's recruitment procedures were not robust. The Appellants had failed to undertake robust recruitment and selection procedures to ensure persons employed were safe and suitable to work with vulnerable people. At the December 2021 inspection, I found the same. I looked at the personnel files of staff members S03, S07, S08 and S06. I saw that the Appellants had failed to make every effort to gain information on the previous

work conduct and 'character of two staff members recently employed to work in the home.'

The panel had regard to the references listed for S06 and S07, noting that both employees had provided two or more references. The panel noted that Ms Lea had been listed as a referee for S06 and it was of the view that as the recruiter, this was inappropriate. However, the panel determined that it was the responsibility of the applicant, not the employer, to obtain references. Therefore, the panel concluded there was insufficient evidence to support the assertion in the charge, in that Ms Lea had made insufficient effort to obtain references for one or more staff members.

Accordingly, this charge is found not proved.

Charge 27.b.

27. Failed to maintain adequate recruitment processes, in that:
    b. References were not investigated.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and S06 and S07's references. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel noted Witness 2's CQC statement that states:

'I looked at the staff file belonging to staff member S07. […] Their current or last employer was recorded as Tesco. Prior to that, S07 had worked for the Contact Company as a call centre operative. The Contact Centre however was not listed as a previous employer reference despite S07 working for them for a year. Instead, a friend of S07's who already worked at Sandrock Nursing Home was listed as S07's second referee (character reference). There was no evidence that the Appellants had queried and obtain an explanation from S07 as to why the

Contact Centre was not listed as a second employer reference in accordance with good due diligence checks.

S07's application form gave two different sets of contact details for a Tesco reference. I saw that there was a previous employer reference cited as from Tesco in S07's staff file. However, when I looked at this reference, I found anomalies that had not been investigated by the Appellants and there was no evidence that Appellants had validated and verified this reference as authentic. […]

The reference had been sent to and received from the referee's personal email address and not an email address connected to Tesco. The reference from the referee was not provided on company letterhead and did not have a company stamp to verify its authenticity. It was clear that the Appellants had not done all that was reasonably practicable to ensure that the source of this reference was credible and reliable in respect of [an applicant's] *previous work conduct and character.*

I checked S06's personnel file for the referee contact details from both previous employers. I found that, although referee details had been provided for Aynsley Care Centre, the referee details for Charlotte House had not been given. There was no evidence that the Appellants had investigated and obtained an explanation from S06 as to why details of a referee from Charlotte House had not been provided in respect of their previous work conduct and performance. Instead, S06 had listed the Appellant, Karen Lea as their second referee (character reference). This raised concerns over potential bias in the Appellant's recruitment process as the Karen Lea was also responsible for interviewing S06 for her post.

I looked at the reference provided by Aynsley Care Centre on the 2 October 2021. The reference referred to S06 as being"suitably qualified as an administrator", which did not correspond with the post S06 had held at the care home. […] Despite this, there was no evidence that the Appellants had followed

this up with either S06 or the referee from Aynsley Care Centre to clarify S06's role, and their skills and abilities whilst employed by them.'

The panel had regard to these references and noted that its assessment of these was consistent with Witness 2's findings, in that there were discrepancies that arose from the reference provided. Whilst the panel was of the view that an investigation into these references was not required, these discrepancies should have been looked into by Ms Lea as part of her due diligence for adequate recruitment processes. The panel was not provided with any evidence to suggest that these discrepancies had been queried with the referees or the relevant companies.

Accordingly, the panel found this charge proved.

Charge 28

28. On 16 December 2021, signed Service User T's record administration sheet to say that you had witnessed the administration of the patient's medication, when the medication had not yet been administered.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1 and the 'Record of Administration' sheet for 24-hour syringe driver for SUT dated 16 December 2021. Ms Lea did not provide the panel with any submissions in relation to this charge.

The panel noted Witness 1's CQC statement that states:

'On 16 December 2021 the hyoscine for the syringe driver arrived in the home at about 16:15. I examined a "record of admiration sheet" [sic] for the all the four medicines to be administered. I took a photograph of the sheet at 16:18 which showed that Karen Lea had witnessed the administration of all the medicines but there was no signature of the nurse who had administered the medicines. I observed Staff member T take the filled syringe to the SUT's room at approx.

16:30 she was alone and not accompanied by Karen Lea indicating the records Karen Lea made were false.'

'[…] At approximately 16:15 observed that the Hyoscine was delivered by the pharmacy and at 16:30 I observed Staff member T complete the preparation of the medicines for the syringe driver and take them to SUT […]'

The panel noted that one of SUT's medications due to be administered, namely, Hyoscine had not been in stock until 16:15 that day and that this medication, including the three other medications (Morphine Sulphate, Midazolam and Sodium Chloride) were administered by Staff member T at around 16:30. The panel acknowledged that there was no time recorded for the administration of these medications, however it accepted the evidence of Witness 1, that she had taken a photograph of the signed sheet at 16:18, before the medication was administered at 16:30. Further, the panel found that Witness 1's written evidence was consistent with her oral evidence, during which she stated that she had been monitoring the situation throughout the afternoon. She said she was concerned that there was a gap in SUT receiving his palliative care medication.

The panel had regard to SUT's Record of Administration sheet for the 24-hour syringe driver and noted that all four medications had been signed as checked by Ms Lea. Witness 1's photographic evidence confirms that this was signed prior to administration with Ms Lea not being present during the preparation or administration of the medication.

Taking into account the evidence before it, the panel determined that this charge is found proved.

Charge 29

29. Your conduct at charge 28 was dishonest, in that you intended for anyone reading Service User T's record administration sheet to believe you had witnessed the administration of their medication.

This charge is found proved in relation to charge 28.

In reaching this decision, the panel had regard to its findings in respect of charge 28 and the legal test for dishonesty as set out in *Ivey v Genting Casinos*. The panel bore in mind that it must first ascertain the actual state of the individual's knowledge or belief as to the facts. Once this has been established, the question of whether the conduct was honest or dishonest is to be determined by applying the objective standards of ordinary and decent people.

The panel noted that Ms Lea had not provided a response to this charge. As a result, it had no evidence from her that would assist it in ascertaining her state of knowledge or belief as to the facts. In her oral evidence Witness 1 told the panel she had spoken to Ms Lea about her premature signature on the sheet but could not recall Ms Lea's response due to the passage of time.

The panel determined that as an experienced Nurse and Registered Manager of the Home, Ms Lea would have been aware that she should not have signed that she witnessed the administration of controlled drugs when she had not. The panel noted its earlier findings, in that Ms Lea had not seen the preparation or the administration at the time of signing SUT's Record of Administration sheet. The panel concluded that Ms Lea would have been aware that it was wrong to make a false declaration when she had not witnessed the administration.

The panel determined that Ms Lea's actions in signing SUT's Record of Administration sheet prematurely, when the medication had not been administered, was dishonest and that she was aware of this at the material time. The panel determined that Ms Lea's conduct would be regarded as dishonest according to the standards of ordinary decent people.

Accordingly, this charge is found proved.

Fitness to practise

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

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

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

Submissions on misconduct and impairment

Mr Edwards referred the panel to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'* He also referred the panel to the relevant cases of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin).

Mr Edwards invited the panel to take the view that the facts found proved are sufficiently serious as to amount to misconduct and were in breach of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"). He

then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, Ms Lea's actions at the charges found proved amounted to a breach of those standards.

In relation to paragraphs 1 and 1.2 of the Code, Mr Edwards submitted that it was Ms Lea's responsibility to ensure that adequate care was provided to residents at the Home. He submitted that whilst it is accepted that Ms Lea was not directly involved in the care of all individual residents, she was responsible for ensuring that medication and other aspects of patient care were provided properly and effectively. He submitted that Ms Lea failed to ensure that fundamentals of care were carried out properly by the staff at the Home.

In relation to paragraphs 2 and 2.1 of the Code, Mr Edwards submitted that in Ms Lea's role as the Registered Manager of the Home, it was incumbent on her to work as part of a team and to ensure that members of staff were delivering care kindly and effectively. Particularly, given the wide range of concerns raised by the CQC.

In relation to paragraphs 8.2- 8.6 of the Code, Mr Edwards submitted that a large number of the charges found proved relate to errors in medication administration and medication management. He submitted that it was Ms Lea's responsibility, as the Registered Manager of the Home to ensure that members of staff were administering medication safely. In addition, to ensure that where issues were raised in relation to medication, she maintained effective communication with colleagues. He submitted that this was fundamental to Ms Lea's role as the Registered Manager.

In relation to paragraphs 10 – 10.3 of the Code, Mr Edwards submitted that Ms Lea was required to ensure that all patient records in relation to their care were accurate and up to date. He explained that this overarching responsibility was set out in Ms Lea's job description. Mr Edward submitted that recording keeping it is a basic nursing skill and element of care. Further, he submitted that where records are inaccurate, this may negatively impact on safe and effective care being delivered to patients.

In relation to paragraphs 19-19.1 of the Code, Mr Edwards submitted that COVID -19 testing and monitoring of staff members was required to reduce the risk of harm to staff and patients. He submitted that Ms Lea's failure to ensure this was properly carried out at the Home put the wellbeing of vulnerable residents at risk and was in breach of government guidelines.

In relation to paragraphs 20-20.2 of the Code, Mr Edward submitted that Ms Lea failed to uphold the standards and values of the Code. He submitted that Ms Lea's actions at charge 29 were dishonest, and that the values of honesty and integrity are fundamental tenets of the nursing profession. He submitted that nurses are expected to act with honesty and integrity and to do not so diminishes public confidence in the nursing profession.

In relation to paragraphs 25-25.2 of the Code, Mr Edwards submitted that Ms Lea was an experienced Registered Home Manager, and was aware of the need for safe levels of staffing and the requirement of staff training. He submitted that Ms Lea failed to ensure that staff training was up to date.

In conclusion, Mr Edwards submitted that cumulatively the charges do amount to misconduct and Ms Lea's actions fell well below the standards expected of a registered nurse, particularly given her seniority. He submitted that all nurses are expected to provide safe and effective care irrespective of experience, however where Ms Lea was tasked with managing a care home and staff, the responsibility is greater.

Mr Edwards then addressed the panel on the issue of impairment and 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.

Referring to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), Mr Edwards submitted that limbs a-d of Dame Janet Smith's "test" are engaged in this case. He submitted that Ms Lea's actions and poor management of the Home for a significant period of time did put

patients at unwarranted risk of harm. He submitted that Ms Lea did bring the profession into disrepute and breached at least one of the fundamental tenets, considering the panel have found that she acted dishonestly.

Mr Edwards submitted that Ms Lea's failures were repeated in respect of different residents and her conduct does demonstrate that there is a real risk of repetition of her actions that placed residents at the Home at risk of unwarranted harm.

With refence to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin), Mr Edwards invited the panel to consider the circumstances that led to these charges and the panel's findings of fact. Further, what steps Ms Lea has taken to strengthen her practice since the allegations arose and likelihood of her repeating the conduct found proved in the future.

Mr Edwards then referred the panel to Ms Lea's bundle of documents, which included a reflective piece relating to the CQC findings and the NMC regulatory concerns, testimonials and a number of training certificates. He submitted that it is a matter for the panel whether any or all of the information before it is sufficient to demonstrate that Ms Lea's fitness to practise is not currently impaired.

Mr Edwards submitted that whilst the panel should not draw any adverse inference from Ms Lea's non-attendance, the panel is limited in assessing whether she has remediated the concerns or shown insight. He submitted that the panel's consideration of Ms Lea's insight is limited to the reflective pieces before the panel. He submitted that these reflections lack detailed understanding and appreciation of the concerns raised. Further, he submitted that and whilst they show some insight and understanding of where things went wrong, Ms Lea's limited insight does not demonstrate that she can practise safely and effectively.

For the reasons set out above, Mr Edwards submitted that it is the NMC's view that Ms Lea's fitness to practise is currently impaired on public protection grounds. He also submitted that a finding of current impairment is also necessary on public interest

grounds to uphold professional standards and maintain confidence in the nursing profession.

Prior to giving legal advice, the legal assessor invited Mr Edwards to address the panel in respect of the contextual evidence in this case.

Mr Edwards acknowledged that when making its decision on impairment the panel are entitled to take into account the context of this case and to consider whether expectations on Ms Lea were too high or whether she received sufficient support to assist her in carrying out her role as the Registered Manager of the Home. He also accepted that the context in which the concerns arose (COVID-19), was a difficult and stressful time. Notwithstanding this, he submitted that it does not decrease or diminish, the expectations of Ms Lea, as the registered Home Manager to ensure the safety of residents and staff.

The panel accepted the advice of the legal assessor which included reference to the relevant cases of *Nandi, Cohen, Grant* and *Rylands v General Medical Council* [1999] Lloyd's Rep Med 139. He also referred the panel to the NMC guidance on impairment (last updated on 27 March 2023).

Decision and reasons on service of Notice of Hearing (heard on 18 April 2024)

At the outset of the resuming hearing, Mr Edwards on behalf of the NMC, informed the panel that Ms Lea was not in attendance. Further, that the Notice of Hearing letter for the resuming hearing had been sent to Ms Lea's registered email by secure email on 8 January 2024. The Notice of Hearing letter for the resuming hearing had also been sent to Ms Lea's RCN representative on 8 January 2024.

Mr Edwards submitted that it had complied with the requirements of Rules 11 and 32 (2) 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 time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Lea's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Lea has been served with the Notice of Hearing for the resuming hearing in accordance with the requirements of Rules 11 and 32 (2).

Decision and reasons on proceeding in the absence of Ms Lea

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

Mr Edwards reminded the panel that Ms Lea's RCN representative in a letter dated 26 September 2023, confirmed that they were content for the hearing to proceed in their absence. He submitted that Ms Lea has not been in contact with the NMC since the last sitting of this hearing and she was not in attendance at the previous sittings of this hearing. He submitted that Ms Lea has made no application for an adjournment and it is in the public interest for an expeditious disposal of this case. Further, he submitted that this case has been ongoing for a considerable amount of time and that it is in the interest of Ms Lea and the NMC that this case proceeds without further delay.

For these reasons, Mr Edwards invited the panel to exercise its discretionary power and to proceed in the absence of Ms Lea, as she had voluntarily absented herself.

The panel accepted the advice of the legal assessor which included reference to Rule 21 and Rule 32.

The panel has decided to proceed in the absence of Ms Lea. In reaching this decision, the panel has considered the submissions of Mr Edwards and the advice of the legal

assessor. It has had regard to the overall interests of justice and fairness to all parties. It noted that:

- Ms Lea's RCN representative had previously informed the NMC in a letter dated 29 September 2023, that they are content for the hearing to proceed in Ms Lea's absence;
- No application for an adjournment has been made by Ms Lea;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- It is in the interest of Ms Lea and the NMC that this case proceeds without further delay; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Lea.

Decision and reasons on misconduct

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

The panel was of the view that Ms Lea's actions amounted to a breach of the Code. The panel considered that the following sections of the Code had been breached in this case:

> ***'1 Treat people as individuals and uphold their dignity***
> ***To achieve this, you must:***
>
> *1.1 treat people with kindness, respect and compassion*
> *…*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *…*

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

…

1.5 respect and uphold people's human rights

…

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

…

4 Act in the best interests of people at all times
To achieve this, you must:
…
4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, […]
…

8 Work cooperatively
To achieve this, you must:

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff

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

8.6 share information to identify and reduce risk, and

…

10 Keep clear and accurate records relevant to your practice This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.
To achieve this, you must:

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
…
10.3 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

…

11 Be accountable for your decisions to delegate tasks and duties to other people
To achieve this, you must:

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

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

…

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

…

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

…

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely, and

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

To achieve this, you must:

…

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

…

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures […]

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

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

20 Uphold the reputation of your profession at all times
To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly […]

…

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the healthcare system
To achieve this, you must:

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

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel went on to consider whether Ms Lea's actions in the charges found proved amounted to misconduct. The charges found proved relate to a number of service users and diverse failings, which the panel consider fall under the following categories:

- Medication management and PRN protocols;
- Record keeping;
- Adherence to COVID 19 guidance;
- Assessing needs;
- Care planning;
- Risk management;
- Wound management;
- Recruitment of staff;
- Staffing levels and training;

Medication management

In determining whether Ms Lea's actions amounted to misconduct, the panel took into account the following charges in respect of medication management:
2.a.i.-v,3.a., 5.b., 7.b.iii- iv., 8.a.ii., 8.b.i., 8.c.i.,8.d.,9., 10.f.i.,11.b.,12.b.i., 13., 14.b.,14.a.i-ii., 16.c.i-ii.,18.a. ,20. and 21.a-b.

The panel was of the view that Ms Lea did have an overarching responsibility as a registered nurse and Registered Manager to ensure that medication was managed effectively and administered safely. The panel noted that Ms Lea had failed to ensure that multiple residents' medication at the Home were stored appropriately and in stock, the panel did not consider this to be an isolated incident and therefore, was serious enough to amount to misconduct. The panel also found that medications had not been administered safely, particularly in respect of SUB on more than one occasion. The panel also considered Ms Lea had failed in respect of various other service users, to

ensure that blood sugar testing strips were in date or in stock so that their diabetes could be safely monitored.

In respect of charges 5.b. and 16.c.i. the panel considered that these charges involved the management of controlled drugs and it was of the view that Ms Lea's actions in these charges were particularly serious, in that controlled drugs were not administered safely and some went unaccounted for.

In relation to charges 2.c.i-ii., 5.c.i-ii.,6.b., 7.c.i., 7.c.iii. and 16.b., the panel found that PRN protocols were not place at the Home for medications prescribed to service users B, G, H, and I. The panel considered it was Ms Lea's responsibility to ensure that these were in place so that staff at the Home could safely manage and administer medications. The panel considered that the PRN protocols would provide clear guidance on what PRN medication is available for use by an individual resident, what the medication is used for and how it may interact with other prescribed medication. The panel also considered that in respect of charge 18.a., SUV had not received their prescribed Sertraline for a period of seven days. The panel was of the view that, given the potential for withdrawal symptoms from this particular medication this omission placed SUV at a risk of unwarranted harm.

The panel acknowledged that whilst all nursing staff at the Home were individually responsible for their own medication administration and management, Ms Lea had failed to identify the issues that had occurred, over a significant period of time, in respect of several service users, which may have put residents at risk of harm.

The panel found that Ms Lea's actions in respect of medication management at the Home breached paragraphs 1.2, 3.1, 11.3, 18.2,18.3 and 18.4 of the Code. The panel concluded that Ms Lea's actions collectively in the charges above fell far below such standards expected of a registered nurse. The panel determined that Ms Lea's actions were sufficiently serious to amount to misconduct.

Record keeping

In determining whether Ms Lea's actions amounted to misconduct, the panel took into account the following charges in respect of record keeping:
1.c.,2.d.iii.,2.f.i., 2.g.ii.1-7., 2.g.iii.,3.c.,4.a.i.-viii.,4.c.,5.a.i-v., 5.d., 6.c.,8.a.ii.-iii.,10.a.,10.f.ii.-iii.,10.j., 11.a.i.,12.a.,12.c.,15.a.i.-ii., 15.a.iv,17.,18.b and 28.

The panel was of the view that Ms Lea did have an overarching responsibility to ensure that accurate records were kept at the Home. The panel noted its earlier findings in respect of service users A, D, F, G, H, M, P, U and V, in that Ms Lea had failed to ensure that they had an up-to-date allergy status in their notes. The panel was of the view that whilst it is the responsibility of all staff administering medication to establish a resident's allergy status, this was not an isolated failure, and it could have been picked up and rectified in a timely way if Ms Lea had appropriate auditing systems in place. The panel considered that this failure had the potential to put nine service users at risk of harm as, any staff at the Home would be unable to establish the allergy status of a resident without this information.

The panel considered that there had been multiple incidences of inaccurate recording of medication administration in relation to a number of service users. The panel acknowledged that it was the responsibility of individual nursing staff to ensure that their own record keeping was accurate. Notwithstanding this, the panel was of the view that Ms Lea as the Registered Manager of the Home had failed to have appropriate oversight of record keeping and had failed to address the multiple discrepancies that occurred over an extended period of time, including medication stock balances and diabetes testing.

The panel considered that SUB's records contained contradictory information regarding their care and that their PEEP plan was inadequate. The panel was of the view that it was important for such information to be accurate and sufficiently comprehensive to assist other health professionals attending the Home to fully understand the plan and ensure the continuity of safe and effective care. The panel also considered that SUB's weight had not been monitored over a significant period of time (November 2020-

August 2021) and Ms Lea had failed to ensure that this was done in accordance with SUB's care plan.

In respect of charges 28 and 29, the panel considered that this was an incident where Ms Lea was directly involved in the care of a patient and had dishonestly recorded to say that she had witnessed the administration of SUT's controlled drugs when she had not. The panel considered that patients, fellow practitioners, and members of the public would expect nurses to act with honesty and integrity at all times and that Ms Lea's dishonest conduct was particularly serious.

The panel found that Ms Lea's actions in respect of recordkeeping at the Home breached paragraphs 1.2 and 10-10.6 of the Code. The panel found that Ms Lea's dishonest behaviour in respect of recordkeeping also breached paragraph 20.2 of the Code. The panel concluded that Ms Lea's actions collectively in the charges above fell far below the standards expected of a registered nurse, and that members of the public and fellow professionals would consider her behaviour wholly unacceptable. The panel determined that Ms Lea's actions were sufficiently serious to amount to misconduct.

Adherence to COVID 19 guidance

In determining whether Ms Lea's actions amounted to misconduct, the panel took into account the following charges in respect adhering to COVID 19 guidance in the Home: 2.i.i-ii., 10.d.xi., 19.c.,19.d.ii, 23.a.- d. and 24.

The panel was of the view that Ms Lea did have an overarching responsibility to ensure that all staff were adhering to COVID 19 guidance, to reduce risk to patients and staff. The panel considered that Ms Lea had failed to ensure patients bedrooms were deep cleaned and that all members of staff were taking weekly LFT and PCR tests. The panel also noted that spreadsheet had not be set up till July 2021, despite Ms Lea being reminded of this requirement in April 2021. Further, the panel considered that temperature check records in respect of SUB and SUW were inadequate and had not been carried out consistently. In respect of SUM and SUW the panel also found that their COVID 19 risk assessments were generic and not specific to the individual.

The panel bore in mind that the such measures during the COVID-19 pandemic were important to prevent the spread of COVID 19 and to reduce risk, particularly for vulnerable individuals at the Home but also for staff. The panel acknowledged that it was the responsibility of individual staff to ensure they were testing regularly and that residents' temperature checks were carried out. However, the panel was of the view that as the Registered Manager of the Home, Ms Lea was responsible for ensuring there were adequate systems in place in this regard. The panel considered that Ms Lea was in a position of trust, overseeing the care of residents, their relatives and the wellbeing of her staff.

The panel found that Ms Lea's actions in respect of not adhering to COVID 19 guidance at the Home breached paragraphs 1.2,13.4 and 19.3 of the Code. The panel concluded that Ms Lea's actions collectively in the charges above fell far below the standards expected of a registered nurse and Registered Home Manager. The panel determined that Ms Lea's actions were sufficiently serious to amount to misconduct.

Assessing resident needs

In determining whether Ms Lea's actions amounted to misconduct in respect of assessing resident needs in the Home, the panel took into account charges 2.e.i and 19.a.-b. The panel was of the view that Ms Lea did have an overarching responsibility to ensure the delivery of person-centred and individualised care by regularly assessing resident's needs.

Regarding charge 2.e.i., the panel considered its earlier findings that SUB's mental capacity assessment completed by Ms Lea was inadequate, in that it did not identify specific issues for which capacity had been assessed. The panel was of the view that as an experienced nurse and Registered Manager, Ms Lea would have been aware of what this assessment was required to identify and that these findings should have been documented. The panel therefore found that she had failed to appropriately assess the needs of this vulnerable resident.

Regarding charge 19.a., the panel considered that Ms Lea had failed to ensure that SUW had not been deprived of their personal possessions. The panel bore in mind its earlier findings that SUW was deemed to have capacity and was clearly agitated about not having access to their wallet. In addition, Ms Lea had not taken any action by the December 2021 CQC inspection, to prevent staff from removing SUW's wallet despite being challenged by CQC regarding this in April 2021. The panel was of the view that Ms Lea's actions showed a clear disregard for the basic rights of the individual and caused the resident unnecessary and repeated distress.

In relation to charge 19.b., the panel considered that Ms Lea failed to adequately investigate SUW's account that they had been pushed over by another resident. This had resulted in an injury that required admission to hospital. By not investigating this incident, Ms Lea had failed to prevent any further harm to SUW and prevent potential risk of harm to other residents.

The panel found that Ms Lea's actions in respect of assessing residents needs in the Home breached paragraphs 1.1.1.2,1.5 and 4.3 of the Code. The panel concluded that Ms Lea's actions collectively in the charges above fell far below the standards expected of a registered nurse and wholly unacceptable. The panel determined that Ms Lea's actions were sufficiently serious to amount to misconduct.

Care planning

In determining whether Ms Lea's actions amounted to misconduct, the panel took into account the following charges in respect of care planning: 2.d.iii., 10.d.i., 10.d.iv., 10.d.vii., 10.d.xi and 10.h.ii.

Regarding charge 2.d.iii., the panel acknowledged that whilst it had found that this charge amounted to misconduct in respect of recordkeeping, it also identified that Ms Lea's failure in this charge concerned poor oversight of care planning. The panel was of the view that SUB's SALT assessment was fundamental to their care planning and without clear information in this regard, those directly involved in the care of the resident may have lacked sufficient information to deliver safe and effective care.

In respect of charges 10.d.i., 10.d.iv., 10.d.vii., 10.d.xi and 10.h.ii., the panel considered that Ms Lea had failed to ensure that SUM's care plans regarding capacity, COVID 19 and skin care were adequate and that a capacity assessment had taken place regarding SUM's use of a wheelchair safety belt. The panel determined that these were not isolated incidents in relation to SUM's care planning and that there were multiple deficiencies in essential information to support consistent and effective care of SUM.

The panel found that Ms Lea's failures in respect of assessing residents' needs in the Home breached paragraphs 8.6 and 10 of the Code. The panel concluded that Ms Lea's failures collectively in the charges above fell far below the standards expected of a registered nurse and were sufficiently serious to amount to misconduct.

Risk management

In determining whether Ms Lea's actions amounted to misconduct, the panel took into account the following charges in respect of risk management: 1.c.,2.f.i., 3.c., 4.c., 5.d., 10.d.iv., 10.e., 10.j., 12.c., 17. and 18.b.

The panel was of the view that Ms Lea as the Registered Manager of the Home, had a duty to ensure that residents had up to date appropriate risk assessments in place. Although individual staff had a responsibility to complete and follow the risk assessments, Ms Lea had a duty to have systems in place to provide oversight and ensure risks were being appropriately managed.

In relation to charges 1.c.,3.c., 4.c., 5.d., 10.j., 12.c., 17. and 18.b., the panel acknowledged that whilst it had found that these charges amounted to misconduct in respect of recordkeeping, it also identified that Ms Lea's failures in these charges concerned poor risk management. The panel noted its earlier findings in respect of record keeping that this failure had the potential to put nine residents at risk of harm as staff at the Home would be unable to establish the allergy status of a resident without this vital information.

Regarding charges 2.f.i, 10.d.vi. and 10.e., whilst the panel had found that these charges amounted to misconduct in respect of poor care planning, it also found that Ms Lea had failed to reduce the risk to vulnerable service users, by ensuring that adequate care plans were in place in relation to service users B and M.

The panel therefore found that Ms Lea's actions at these charges also breached 19.1 of the Code, in that she failed to take measures to reduce the likelihood of harm to these residents.

Wound management

In determining whether Ms Lea's actions amounted to misconduct, the panel took into account the following charges in respect of wound management: 10.h.ii.-iv. and 10.i.iii. The panel considered that as the Registered Manager of the Home, Ms Lea had the responsibility to ensure that there was a system in place to ensure appropriate and effective wound management.

The panel considered that several failures had occurred in respect of SUM's wound management, including a failure to ensure their skin plan was adequate and adhered to and that their wound dressings were adequately changed.

The panel acknowledged that whilst nursing staff at the Home were individually responsible for the direct care of this resident's wounds, Ms Lea had failed to identify that wound care records were not adequately maintained over a prolonged six-week period, and therefore, subsequent management of the wounds may have been inadequate. The panel was of the view that Ms Lea's lack of oversight in this regard could have placed SUM at risk of unwarranted harm.

The panel found that Ms Lea's actions in respect of wound management at the Home breached paragraphs 1.4, 13.2 and 19.1 of the Code. The panel concluded that Ms Lea's actions collectively in the charges above fell far below the standards expected of a registered nurse and Registered Home Manager. The panel determined that Ms Lea's actions were sufficiently serious to amount to misconduct.

Recruitment of staff

In determining whether Ms Lea's actions amounted to misconduct in respect of recruitment of staff, the panel took into account its earlier findings in relation to charge 27.b.

The panel considered that there was a duty upon Ms Lea as the Registered Home Manager to maintain adequate recruitment processes. The panel considered that Ms Lea had failed to investigate the discrepancies that arose from the references provided from a new member of staff and that her actions were in breach of paragraph 25.1 of the Code.

Although the panel considered Ms Lea did not follow the proper processes in relation to recruitment and her actions amounted to poor practice, it did not find that Ms Lea's actions in this charge alone were sufficiently serious as to amount to misconduct.

Staffing levels and training

In determining whether Ms Lea's actions amounted to misconduct in respect of staffing levels and training in the Home, the panel considered its findings in relation to charges 25.a.-b. and 26.a.

The panel considered that there was a duty upon Ms Lea to maintain proper levels of staffing and training standards in the Home. The panel found that not all members of staff had completed their training and that the training matrix did not include all members of staff. In addition, it found there had been no dependency tool/and or staffing level policy in place at the material time. The panel considered the importance of staff training is to ensure that staff have the required skill to provide safe and effective care and meet the needs of the residents at the Home.

The panel bore in mind that without a dependency tool and/or staffing level policy Ms Lea would have been unable to assess proper levels of staffing.

As a Registered Manager of the Home, Ms Lea had overall responsibility for the care and safety for both residents and staff. This included a duty to maintain safe staffing levels and employ staff who were appropriately trained to meet the needs of those

residents. By failing to do this, the panel concluded Ms Lea put both residents and staff at potential risk of harm. The panel found that Ms Lea's actions in respect of staffing levels and training in the Home breached paragraphs 25.1 and 25.2 of the Code. The panel determined this was serious and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide whether, as a result of this misconduct, Ms Lea's fitness to practise is currently impaired.

Nurses and midwives 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 and midwives 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/their fitness to practise is impaired in the sense that S/He/They:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered that limbs a, b, c and d of the above test were engaged by Ms Lea's past actions. The panel found that Ms Lea's failures placed the residents at the Home at an unwarranted risk of harm through lack of assessment of needs and failing to ensure that appropriate policies and procedures were in place and followed. The panel considered that honesty and integrity are fundamental tenets of the nursing profession and that patients, fellow professionals and members of the public expect nurses to act with honesty and integrity at all times. The panel determined that Ms Lea's actions, breached fundamental tenets of the nursing profession and brought the nursing profession into disrepute.

The panel are aware that this is a forward-looking exercise, and accordingly it went on to consider whether Ms Lea's misconduct was remediable and whether it had been remediated.

Having regard to the case of *Cohen*, the panel considered whether the misconduct identified was capable of remediation. It determined that the misconduct is such that it may be difficult to remediate, given the finding of dishonesty and Ms Lea's wide ranging failures found proved by the panel.

Before considering any evidence of insight and strengthened practice, the panel took into account the context in which Ms Lea's misconduct occurred. The panel acknowledged that at the material time, the COVID 19 pandemic raised particular challenges for health and social settings, particularly care homes, including the residents, their families and the staff that cared for these residents. The panel also took into account the contextual evidence regarding the CQC inspections, the challenges Ms Lea reported to have faced with the Registered Home Provider and how this may have created a challenging working environment.

The panel went on to consider whether Ms Lea remained liable to act in a way that would put residents at risk of harm, would bring the profession into disrepute and breach the fundamental tenets of the profession in the future. In doing so, the panel considered whether there was any evidence of insight and remediation.

Regarding insight, the panel carefully considered the material before it which included; Ms Lea's reflection on the regulatory concerns, a response to the CQC findings, references and resident feedback. The panel noted that the references and resident and relative feedback attested to Ms Lea's professionalism and patient care. Taking into account Ms Lea's reflections, the panel considered that Ms Lea had responded to some of the regulatory concerns and explained what she would have done differently. However, the panel considered that her reflection lacked detail, showed limited insight into the seriousness of her failings and how they impacted on her colleagues, the residents at the Home and the public confidence in the nursing profession.

The panel was also of the view that Ms Lea had not fully understood the gravity of the concerns raised by the CQC. Further, Ms Lea had not provided any information regarding why these failures had occurred, or how the contextual factors in this case

may have affected her ability to oversee safe and effective care. The panel therefore determined that Ms Lea has demonstrated limited insight.

The panel then considered the evidence before it in determining whether or not Ms Lea has taken steps to strengthen her practice. The panel considered that all of the training certificates listed in the RCN letter dated 26 September 2023 were relevant to the charges found proved. However, the panel was not provided with any information to demonstrate how Ms Lea would put the theory of this training into practice. Further, the panel noted that the RCN letter dated 26 September 2023 reported that Ms Lea had been working at the Home in an administrative capacity and that she had not worked as a registered nurse since 2022. As a result, the panel had no information before it to demonstrate that Ms Lea was capable of practising kindly, safely and professionally, since the concerns were raised.

The panel considered that Ms Lea's failures in respect of the Home occurred over a sustained period of time despite several concerns raised by the CQC regarding her management of the Home, over two inspections in April and December 2021. The panel heard from Witness 2 that similar issues had also been raised with Ms Lea at earlier inspections since she became the Registered Home Manager in 2011.

The panel bore in mind that Ms Lea has since de-registered as the Registered Manager of the Home and that she reports to be administratively supporting the new Registered Manager of the Home, implementing new processes. The panel also considered that Ms Lea's dishonesty was at the lower end of the spectrum and her actions were not for any personal or financial gain, rather it appeared to be for the purpose of expediting the process of medication administration. Notwithstanding this, the panel was of the view that Ms Lea's unprofessional behaviour had the potential to put resident's at a real risk of harm and given her limited insight, the panel found that there is a risk of repetition.

The panel was of the view that Ms Lea remained liable to act in a way which could place patients at risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession in the future. The panel also found that Ms Lea remained liable to act dishonestly as she had not demonstrated any insight into her actions. The panel

also concluded that Ms Lea may not have fully understood why her actions were dishonest, as this dishonesty occurred whilst an inspection was taking place. Accordingly, the panel determined that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel concluded, given the Ms Lea's position of seniority at the Home and the wide ranging nature of her misconduct, public confidence in the profession and in the regulator would be undermined if a finding of impairment were not made in this case. Therefore, the panel also finds Ms Lea's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Edwards submitted that this is a case that involved serious and wide ranging failures, therefore the appropriate and proportionate order in this case is a striking-off order. He invited the panel to take into account the SG in relation to seriousness and considering a striking-off order. He referred to the following section of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?'*

Mr Edwards then outlined what the NMC considered to be the aggravating and mitigating features of this case.

Mr Edwards submitted that in Ms Lea's role as the Registered Manager of the Home, she failed to ensure proper functioning of the Home and referred to the categories previously identified by the panel in regard to her misconduct. He submitted that these managerial concerns were heightened by virtue of Ms Lea's dishonest behaviour. In all the circumstances, Mr Edwards submitted the misconduct identified does raise fundamental questions about Ms Lea's professionalism, such that public confidence would be seriously undermined by her continued registration. He also submitted that the panel may consider that Ms Lea's actions were demonstrable of serious, harmful and deep seated attitudinal concerns, that she has failed to remedy.

Mr Edwards then addressed the panel in respect of other available sanctions. Regarding a conditions of practice order, he submitted that this order would be wholly inappropriate in the circumstances of this case. He submitted given the nature and seriousness of the facts found proved, the panel would be unable to formulate conditions that would adequately protect the public and satisfy the public interest concerns.

In relation to a suspension order, Mr Edwards submitted that a suspension order would not be sufficient as Ms Lea has failed to remediate the concerns and demonstrate sufficient insight into her failings. He submitted that there is a risk of Ms Lea repeating the conduct found proved, were she to be in a managerial position again and subsequently a significant risk of harm to patients.

Mr Edwards submitted that Ms Lea's misconduct is fundamentally incompatible with being a registered professional and invited the panel to impose a striking-off order.

Decision and reasons on sanction

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

The panel considered the following to be aggravating features in this case:

- Ms Lea's misconduct covered a large number of varied concerns, which calls into question her overall practice and management of the Home;
- Concerns took place over a prolonged period of time;
- As a result of Ms Lea's failures there was a real risk of harm to residents;
- Ms Lea was an experienced nurse and Registered Manager in a position of trust when the concerns occurred; and
- There had been prior concerns at the Home whilst Ms Lea was the Registered Manager of the Home, that had been brought to her attention by the CQC on more than one occasion.

The panel considered the following to be mitigating features in this case:

- Ms Lea's misconduct occurred during the COVID 19 pandemic and there

appeared to be a lack of support from the Registered Home Provider; and

- Efforts Ms Lea made after she had been de-registered as the Home Manager to support the Home in an administrative capacity to become CQC compliant.

Prior to considering the sanctions in ascending order, the panel had regard to the NMC's guidance on considering sanctions for serious cases and assessed the dishonesty in this case. It noted that the most serious forms of dishonesty, which are most likely to question whether a nurse should be allowed to remain on the register, often involve:

- *vulnerable victims*
- *[…]*
- *direct risk to patients*

[…]

The panel noted that dishonesty will be generally considered less serious in cases of:

- *one-off incidents*
- *opportunistic or spontaneous conduct*
- *no direct personal gain*
- *no risk to patients*
- *incidents in private life of nurse, midwife or nursing associate'*

Having regard to this case, the panel considered that Ms Lea's dishonest behaviour was an isolated incident. The panel also considered that Ms Lea's dishonesty did not result in any direct personal gain. Balancing these factors as a whole, the panel considered that the dishonesty in this case was at the lower end of the spectrum of seriousness.

The panel then went onto consider what action, if any, to take in this case.

The panel first considered whether to take no action, but concluded that this would be inappropriate in view of the seriousness and wide ranging nature of the misconduct. The

panel decided that taking no action would not protect the public and would not satisfy the wider public interest.

The panel next considered whether a caution order would be appropriate in the circumstances. The panel took into account the SG, which states that a caution order may be appropriate where:

> *"…the case is at the lower end of the spectrum of impaired fitness to practise, however the Fitness to Practise Committee wants to mark that the behaviour was unacceptable and must not happen again."*

The panel considered that Ms Lea's misconduct was not at the lower end of the spectrum of impaired fitness to practise, given that it involved dishonesty and failures which occurred over a sustained period of time that put residents at a real risk of harm. The panel also considered that staff and visitors to the Home were also put at risk of harm due to the failure to follow proper COVID 19 procedures. The panel considered that a caution order would fail to place any restrictions on Ms Lea's practice and would not protect the public. Furthermore, it would not address the seriousness of this misconduct, and the public interest, in maintaining confidence in the nursing profession and in the NMC as a regulator.

The panel next considered whether placing conditions of practice on Ms Lea's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be appropriate, proportionate, measurable and workable.

The panel had regard to the wide ranging nature of Ms Lea's failures and it did not consider that it was possible to identify workable, measurable and practicable conditions of practice to address Ms Lea's unprofessional behaviour. The panel considered that a conditions of practice order would not mark the seriousness of Ms Lea's misconduct, adequately protect the public or address the wider public interest in maintaining confidence in the nursing profession and in the NMC as a regulator.

The panel went on to consider whether to impose a suspension order. The panel had regard to the SG, which states that a suspension order may be appropriate where the following factors are apparent:

- *a single instance of misconduct but where a lesser sanction is not sufficient*
- *no evidence of harmful deep-seated personality or attitudinal problems*
- *no evidence of repetition of behaviour since the incident*
- *the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*

With regard to honesty, the panel had no material before it to demonstrate that Ms Lea had developed any insight into the importance of honesty and integrity to the role of a registered nurse. However, the panel did not identify any evidence of harmful deep-seated personality or attitudinal problems.

The panel considered that Ms Lea's other failings could not be considered a single incident. The panel determined that there was evidence that her failings predated the CQC inspections in 2021. In addition, the panel noted that Ms Lea was given recommendations by CQC in April 2021 and failed to address many of them by the time of the second inspection in December 2021. Therefore the panel considered the risk of repetition was high. Taking all of this into account, given Ms Lea's wide ranging failures in respect of the Home and her lack of evidence of insight, the panel did not consider that a period of suspension would be sufficient to protect patients and public confidence in nurses and to maintain professional standards.

The panel went on to consider whether to impose a striking-off order. The panel had regard to the SG which states that:

> *This sanction is likely to be appropriate when what the nurse, midwife or nursing associate has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:*

- *Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
- *Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel determined that Ms Lea's wide ranging failures over a sustained period, consistent lack of professionalism, despite recommendations from the CQC, and a lack of insight into the seriousness of the concerns, were significant departures from the standards expected of a registered nurse. Ms Lea was the Home Manager caring for particularly vulnerable residents and put them at risk of harm for a prolonged period of time. The panel found that this behaviour is fundamentally incompatible with her remaining on the register. The panel was of the view that, in light of its finding of serious misconduct, to allow Ms Lea to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel reminded itself that honesty and integrity are fundamental tenets of the nursing profession, and it considered that Ms Lea's behaviour did raise fundamental questions about Ms Lea's professionalism. Given Ms Lea's wide ranging failures, dishonest behaviour and lack of insight, the panel considered that public confidence in nurses would not be maintained unless Ms Lea were permanently removed from the register. It considered that a striking-off order is the only sanction sufficient to protect patients and members of the public and to maintain public confidence in the profession.

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 nursing profession a clear message about the standard of behaviour required of a professional and a registered nurse.

Interim order

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

Submissions on interim order

Mr Edwards submitted that an interim suspension order is necessary for the protection of the public and is otherwise in the public interest. He relied on the panel's earlier findings to support his submission. He therefore invited the panel to impose an interim suspension order for a period of 18 months to cover the 28-day appeal period and for the resolution of any potential appeal.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

Having regard to the findings in this case, the panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. Having regard to the seriousness of the misconduct in this case and the reasoning for its decision to impose a striking-off order, the panel considered that to not impose an interim order would be inconsistent with its previous findings.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order.

The panel therefore imposed an interim suspension order for a period of 18 months to cover the 28-day appeal period. If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Ms Lea is sent the decision of this hearing in writing.

That concludes this determination.

This will be confirmed to Ms Lea in writing.