Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday 6 - Friday 10 September 2021
Monday 20 - Wednesday 22 December 2021

Virtual Meeting

Name of Registrant:	**Miss Alexandra Tarlea**
NMC PIN:	15L0233C
Part(s) of the register:	RN1: Registered Nurse – Adult (2 December 2015)
Area of registered address:	Romania
Type of case:	Misconduct
Panel members:	Christina McKenzie (Chair, Registrant member) Carla Hartnell (Registrant member) Colin Sturgeon (Lay member)
Legal Assessor:	Tracy Ayling QC (6 – 10 September 2021) Michael Bell (20 – 22 December 2021)
Hearings Coordinator:	Vicky Green (6 - 10 September 2021) Graeme King (20 -21 December 2021) Teige Gardner (22 December 2021)
Facts proved:	2a, 2c, 3a, 3b, 3c, 4a, 5, 6a, 6b, 6c, 7b, 7c, 7d, 7e, 9, 10, 11, 12a, 12b and 13
Facts not proved:	1, 2b, 4b, 7a, 8 and 14
Fitness to practise:	Impaired
Sanction:	**Strike-off order imposed**
Interim order:	**Interim suspension order (18 months)**

Decision on Service of Notice of Meeting

In response to the current COVID-19 crisis, emergency changes were made to the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules). The emergency changes allow for the Notice of Meeting (the Notice) to be sent by the Nursing and Midwifery Council (NMC) by email instead of by recorded delivery post. This email must be sent securely to a confirmed email address for the Miss Tarlea and/or her representative.

The panel was informed at the start of this meeting that the Notice had been sent to Miss Tarlea's registered email address on 19 May 2021 and took into account that the provided details of the allegations, the time, dates and the nature of the meeting. The notice made clear that the case would be considered at a meeting, and would be held in private on or after 21 June 2021.

The panel accepted the advice of the legal assessor.

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

Details of charges, as amended

That you, a registered nurse, working at Maumbury Care Home:

1. On or around February 2017, did not escalate concerns raised by Relative A that Resident A may need treatment for high blood sugar **[Not proved]**

2. Did not properly manage Resident A's diabetes on 10 March 2017, in that you:

    a. Did not ensure the resident's blood sugar was monitored between the hours of 10:00 and 16:30 **[Proved]**

b. Did not provide the resident with the appropriate food to raise their blood sugar level and/or in line with their safe swallow plan **[Not proved]**

c. Did not call 999 immediately when the resident became drowsy **[Proved]**

3. Provided inappropriate care to Resident A when he was choking in that you:

a. Used a suction machine on Resident A inappropriately and when not trained to do so **[Proved]**

b. Used tissue to clean Resident A's mouth which was contrary to the care plan **[Proved]**

c. Did not call 999 immediately when Resident A had difficulty breathing **[Proved]**

4. Did not appropriately manage Resident B's medication in that:

a. On 7 March 2017 you created a PRN Medication Care Plan for Morphine sulphate for Resident B and did not record the time interval between doses **[Proved]**

b. On 7 June 2017 you did not ensure the prescribed eye ointment was administered to Resident B **[Not proved]**

5. Did not arrange a continence assessment for Resident B **[Proved]**

6. Did not safely manage Resident B's skin integrity in April 2017 in that you:

a. Did not escalate a deterioration in Resident B's skin **[Proved]**

b. Did not ensure a body map was completed or photograph was taken or escalate the absence of a body map / photograph **[Proved]**

c. Did not ensure sorbaderm cream was applied twice a day, or in the alternative that application was recorded **[Proved]**

7. Did not manage Resident C's pain appropriately in that you:

a. Did not record and/or administer Oramorph when changing their sacral sore dressings on 1 June 2017 **[Not proved]**

b. Did not complete a pain chart to assess the resident's pain **[Proved]**

c. On 27 May 2017 did not administer paracetamol **[Proved]**

d. Did not discuss the paracetamol medication with their GP before varying the frequency of the dose **[Proved]**

e. On 28, 30 and 31 May 2017 did not administer paracetamol at the frequency directed **[Proved]**

8. Did not escalate or ensure that the tissue viability and wound care plan was updated and/or complete a body map between 30 January 2017 and 3 April 2017 for Resident C **[Not proved]**

9. Created topical medication application records for dermal lotion/cream and Medihoney for Resident C but did not ensure this was being applied, or in the alternative ensure a record of application was kept, during the month of May 2017 **[Proved]**

That you, a registered nurse at Queen Charlotte Nursing Home:

10. On 25 December 2017, updated Resident D's care plan and did not ensure there were clear instructions in relation to medication administration **[Proved]**

11. On 16 January 2018, did not administer paracetamol to Resident D **[Proved]**

12. On 18 January 2018:

a. Did not record how Resident D's pain levels should be assessed; **[Proved]**

b. Did not update Resident D's care plan to show that morphine had been prescribed by the doctor **[Proved]**

13. On 27 January 2018, did not ensure morphine was administered to Resident D when you noted they were painful when touched **[Proved]**

14. On 27 January 2018, when updating Resident D's care plan in respect of nutrition, did not ensure there was an explanation as to why a pureed diet was recommended when Resident D was at risk of choking and/or why this was contrary to the SALT recommendation **[Not proved]**

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

Decision and reasons on amending the charges

The panel noted that charges 2c, 2d and 2f could not be found proved in any event as these sub-charges were not relevant to the stem of charge 2. It considered that the alleged mischief in charges 2c, 2d and 2f was serious, and supported by strong evidence and local admissions, but that it would have to find them not proved based on the current wording of the stem of the charge. The panel considered that to have charges 2c, 2d and 2f amended into a separate charge would better reflect the evidence in this case. It sought to remove charges 2c, 2d and 2f from charge 2 and to make them a standalone charge as underlined below:

<u>Provided inappropriate care to Resident A when he was choking in that you:
a. Used a suction machine on Resident A inappropriately and when not trained to do so
b. Used tissue to clean Resident A's mouth which was contrary to the care plan
c. Did not call 999 immediately when Resident A had difficulty breathing</u>

To keep the charges pertaining to Resident A sequential, the panel sought to add the charge above as charge 3, and every charge thereafter would be moved down one.

The panel accepted the advice of the legal assessor who advised it that Rule 28 states:

> *'(1) at any stage before making its findings of fact, in accordance with [rule 24(5) or (11)] […] the Fitness to Practise Committee, may amend:*

(a) The charge set out in the notice of hearing; or

(b) The facts set out in the charge, on which the allegation is based, unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'

The panel sought representation from the NMC on the matter of amending the charges as proposed. It advised the panel that:

'I [NMC Senior Lawyer] am content that it provides clarity regarding the matters alleged and that it can be made without injustice to the Miss Tarlea [Miss Tarlea]. The allegations remain the same, the amendments simply make clear that some of the failings related to the care provided when the patient was choking rather than them being specific to diabetes management. The proposed amendment does not change the nature of what is being alleged and does not, in my view, make the allegations more serious.'

The panel noted that Miss Tarlea has not engaged with the NMC for a significant period of time but it considered that it would be in the interest of fairness to advise her of these proposed changes. As such, Miss Tarlea was emailed on 20 December 2021 with the proposed new charge sheet and invited to comment by 08:00 on 21 December 2021. Miss Tarlea did not respond to this email.

The panel considered that the proposed amendments would ensure that the charges better reflect the evidence in this case. It noted the submissions from the NMC stating that it was content for the changes to be made. The panel noted that Miss Tarlea has not responded to the proposed amendments, but that she had not engaged at all with this meeting despite numerous invitations to do so. It considered that the proposed amendment does not contain any new incidents or allegations that were not referred to in the initial bundle that was sent to Miss Tarlea. It therefore determined that the amendment, as detailed above, could be made with no unfairness or injustice caused.

Decision and reasons on facts

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

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

Background

Between 21 April 2017 and 3 May 2018 the NMC received four referrals in which a number of concerns were raised about Miss Tarlea's nursing practice.

The NMC received three separate referrals relating to Miss Tarlea's practice while she was employed as a registered nurse at Maumbury Care Home (Home 1). She was employed at Home 1 from 10 May 2016 until she resigned on 10 July 2017. The first referral was received by the NMC on 21 April 2017 and was made by Relative A in relation to the care provided to Resident A at Home 1. On 22 September 2017, the NMC received a second referral and on 3 October 2017, a third referral from Home 1.

After resigning from Home 1, Miss Tarlea started working at Queen Charlotte Nursing Home (Home 2) on 27 July 2017. She was employed at Home 2 until 30 April 2018. On 3 May 2018 the NMC received a fourth referral from the safeguarding practice manager at Dorset County Council (DDC) in relation to Miss Tarlea's practice whilst employed at Home 2.

Resident A

Resident A moved into Home 1 on 27 December 2017, where he resided until 10 March 2017. Following a stroke in August 2016, Resident A was unable to swallow properly or to walk or move. He was a diabetic receiving insulin therapy.

Resident B

Resident B was a resident at Home 1 when the charges arose. She was prescribed eye drops and topical cream for a viral infection and there were concerns about her skin.

Resident C

Resident C was a resident at Home 1. She had a major stroke in September 2015 and had a diagnosis of dementia. She required repositioning every four hours following the stroke. Resident C lacked capacity to make decisions in relation to her health and care needs.

Resident D

Resident D was a resident at Home 2. On 20 October 2017 Resident D was admitted into Westhaven Hospital and attended the fracture clinic after she fractured her upper left arm. Resident D was discharged to Home 2 with clear instructions on how to manage the fracture and cast.

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Relative A: Relative of Resident A.

- Witness 1: Care Centre Manager at Home 1.

- Witness 2: Social Worker employed as a Safeguarding Adult Practitioner at DCC.

- Witness 3: Assessment and Support Coordinator at DCC.
- Witness 4: Quality Lead at Agincare Group.
- Witness 5: Safeguarding Adult Practitioner at DCC.
- Witness 6: District Nursing Lead in Dorset.
- Witness 7: Care Assistant at Home 1.
- Witness 8: Clinical Lead at Home 2.
- Witness 9: Deputy Manager at Home 2.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence, including written submission from the NMC.

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

Charge 1

That you, a registered nurse, working at Maumbury Care Home:

1. On or around February 2017, did not escalate concerns raised by Relative A that Resident A may need treatment for high blood sugar;

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it, which included the statement of Relative A.

The panel had regard to the written statement of Relative A, who recalls Miss Tarlea saying that Resident A's blood sugar levels were *"high"*. It also had regard to the following information contained within Relative A's written statement:

> *'[Relative B] and I knew [Resident A]'s traits so we knew that if his blood sugar levels were high then he needed some insulin followed by something to eat, but [Miss Tarlea] told us that it was not within her remit to give my grandfather insulin. I said, "Can you please then call a doctor as he can prescribe my grandfather some insulin" but [Miss Tarlea] walked out of the room and did not follow up on it. As a result [Resident A] did not get the insulin he needed that day. This incident occurred in February 2017.'*

There were no medicines administration record (MAR) or contemporaneous records that assisted the panel to determine whether Resident A's blood sugar levels were high as no specific date has been set out in the charge. Further, there was no Blood Sugar Monitoring Chart (BSMC) for February 2017.

The panel therefore concluded that it had insufficient clear evidence before it to allow it to reach any informed decision regarding Resident A's blood sugar level '*on or around February 2017'*.

Charge 2.a

That you, a registered nurse, working at Maumbury Care Home:

2. Did not properly manage Resident A's diabetes on 10 March 2017, in that you:

    a. Did not ensure the resident's blood sugar was monitored between the hours of 10:00 and 16:30

This charge is found proved.

In reaching this decision the panel had regard to Resident A's BSMC, Miss Tarlea's written response within the Incident Report Form dated 10 March 2017, Home 1's Investigation Notes dated 26 June 2017 and the witness statement of Witness 6.

The panel had sight of Resident A's BSMC that contained four entries for 10 March 2017. The panel noted that on 10 March 2017 there was an entry made at 10:00 and then no further entries were made until 16:30.

The panel had regard to Miss Tarlea's hand written notes contained with the Incident Report Form that was completed on 10 March 2017. In her written notes she confirmed that she was on duty and responsible for Resident A's care on 10 March 2017.

Having found that Miss Tarlea was responsible for the care provided to Resident A on 10 March 2017 and that no entries have been made in Resident A's BSMC between 10:00 and 16:30 the panel found this charged proved.

The panel went on to consider the stem of the charge, and whether in not ensuring that Resident A's blood sugar was monitored between the hours of 10:00 and 16:30, Miss Tarlea did not properly manage his diabetes. The panel noted that Resident A was diabetic and on 9 March 2017 he was hypoglycaemic. It noted that the nurse on duty on the night shift of 9 March 2017 called an ambulance as they could not raise Resident A's blood sugar levels.

The panel had regard to Miss Tarlea's responses in the incident report form completed on 10 March 2017 in which she wrote the following:

> *'He totally declined to get up from the bed because he was feeling very tired, which was normal for [Resident A]…*
>
> *[…]*

At lunch time I went to check [Resident A] to see how he is, and was very sleepy, declined lunch and didn't want to get up from the bed.'

The panel also had regard to Miss Tarlea's responses at Home 1's Investigation Meeting on 26 June 2017, in particular:

'He had breakfast, nothing was unusual sleeping moment. He had low blood pressure and he is normally sleepy this is normal for him. Nothing worried me. Around tea time he refused to eat, but I stayed with him and encouraged him to eat, as you need to give food after Lucozade.'

The panel had regard to the witness statement of Witness 6, in particular:

'…by lunchtime [Miss Tarlea's] notes in her statement, "At lunchtime I went to check [Resident A] to see how he is, and very sleepy, declined lunch". At this point it would have been good practice to check [Resident A's] blood sugar levels because she describes him as feeling drowsy which is an indicator of a hypoglycaemic attack. It should have been well known to the nurses in the Home who care for [Resident A], including [Miss Tarlea] that he suffered from hypos so it would have been safe clinical practice to check his blood sugar levels to ensure that they were not low...

[…]

… I would expect any trained nurse to have carried out a blood sugar level check on [Resident A] at lunchtime, when he appeared sleepy.'

The panel noted that, at Home 1's Investigation Meeting on 26 June 2017, Miss Tarlea stated that she did not have any training on how to manage diabetes until after the incident on 10 March 2017.

As Resident A had a hypoglycaemic attack the night before Miss Tarlea started her shift on 10 March 2017, she should have been closely monitoring his blood sugar levels. While Miss Tarlea stated that she did not have any training on diabetes at Home 1 until after 10 March 2017, the panel determined that managing a patient with diabetes, according to a care plan, is a fundamental nursing skill. The panel therefore found that in not following Resident A's care plan by ensuring that his blood sugar was monitored between the hours of 10:00 and 16:30, Miss Tarlea did not properly manage his diabetes.

Charge 2.b

That you, a registered nurse, working at Maumbury Care Home:

2. Did not properly manage Resident A's diabetes on 10 March 2017, in that you:

> b. Did not provide the resident with the appropriate food to raise their blood sugar level and/or in line with their safe swallow plan;

This charge is found not proved.

In reaching this decision, the panel had regard to Home 1's guidance on *'How to avoid Hypos'*, the witness statement of Witness 5 and Witness 6, Miss Tarlea's written response within the Incident Report Form dated 10 March 2017, the Investigation Notes dated 26 June 2017. It also had regard to Resident A's Safe Swallow Plan, Care Plan, Food and Fluid Intake Sheet, and BSMC for 10 March 2017.

The panel had sight of Resident A's Food and Fluid Intake Sheet dated 10 March 2021. It noted that at 17:00 Miss Tarlea recorded in Resident A's BSMC that his blood sugar level had risen to 4.7. Miss Tarlea sought advice from Witness 5 and then gave Resident A *'soup, forticream'* and *'Lucozade'.*

The panel noted that, at this time, Resident A was not hypoglycaemic as his blood sugar level was above 4. Having regard to all of the evidence before it, the panel concluded that

Miss Tarlea acted appropriately and in line with Home 1's guidance and Resident A's Safe Swallow Plan. The panel therefore found this charge not proved.

Charge 2.c

That you, a registered nurse, working at Maumbury Care Home:

2. Did not properly manage Resident A's diabetes on 10 March 2017, in that you:

c. Did not call 999 immediately when the resident became drowsy

This charge is found proved.

In reaching this decision, the panel had regard to Home 1's Diabetes Management Policy and Guidance, Miss Tarlea's written response within the incident report form dated 10 March 2017 and the Investigation Notes dated 26 June 2017.

The panel noted that Home 1's Diabetes Management Policy and Guidance stated that if a resident is drowsy and unable to swallow then 999 should be called. The panel had regard to Miss Tarlea's written statement in the Incident Report Form dated 10 March 2017 in which she noted that Resident A was drowsy and had not eaten lunch. Miss Tarlea did not call 999 when she observed that Resident A was drowsy. Accordingly, the panel found this charge proved.

In respect of the stem of this charge, that Miss Tarlea did not properly manage Resident A's diabetes on 10 March 2017, the panel found that she did not. While it is unclear on whether Resident A could swallow at the point when Miss Tarlea recorded that he was drowsy, the panel was of the view that in not following the Diabetes Management Policy and Guidance in calling 999 when Resident A was drowsy, it is more likely than not that Miss Tarlea did not properly manage his diabetes.

Charge 3.a

This charge is found proved.

That you, a registered nurse, working at Maumbury Care Home:

3. Provided inappropriate care to Resident A when he was choking in that you:

a. Used a suction machine on Resident A inappropriately and when not trained to do so

In reaching this decision, Miss Tarlea's written response within the incident report form dated 10 March 2017, the Investigation Notes dated 26 June 2017 and the witness statement of Witness 6.

The panel had regard to Miss Tarlea's responses in the Investigation Notes dated 26 June 2017 in which she stated the following in response to a number of questions:

Home 1 - *'Have you used suction machines previously?'*
Miss Tarlea – *'No I have never used one, I can't remember in training.'*

Home 1 – *'Why did you think about using this?'*
Miss Tarlea – *'Because of the phlegm, to clear mouth, to help him.'*

Home 1 – *'Were you confident when using this?'*
Miss Tarlea – *'Well I know it wasn't hard, tube in correct place in mouth and suck. At this time the adrenaline was flowing, so if I had to do it now, it would be different.'*

Home 1 – *'Which one do we have?'*
Miss Tarlea – *'I don't know which one we have now, as I think I broke it, I didn't know what was the correct tube, I used the big one and I put it a little bit down, like*

to his gag reflex and then the tube slipped down his throat. Then everything came back up.'

The panel also had regard to the witness statement of Witness 6 in which she stated the following:

'There was a concern that [Miss Tarlea] used a suction machine on [Resident A], which is also written in her statement. When using a suction machine you should only ever do "mouth suction", which is when the suction machine only goes around the front of the patient's mouth cavity if they have secretion. The suction machine should only ever be used around the mouth area and never the throat area. It seems that [Miss Tarlea] ended up putting the tube too far down. [Resident A's throat, as outlined in her statement, which triggered his gag reflex and he ended up vomiting and aspirating some of that vomit. [Miss Tarlea] should not have used the suction machine at all and there was no need for it to be used. It was not outlined in [Resident A] Care Plan that a suction machine should be used for him, and I would not expect it to be outlined in the Care Plan.'

Having regard to all of the above, the panel determined that Miss Tarlea inappropriately used a suction machine on Resident A. During Home 1's investigation, Miss Tarlea confirmed that she could not remember being trained in the use of suction machines. In any event, the panel considered that she used the incorrect equipment (specifically the wrong suction tube) and the incorrect technique on Resident A.

The panel noted that suction was not recommended in Resident A's Care Plan. The panel therefore found this charge proved.

Charge 3.b

That you, a registered nurse, working at Maumbury Care Home:

3. Provided inappropriate care to Resident A when he was choking in that you:

b. Used tissue to clean Resident A's mouth which was contrary to the care plan

This charge is found proved

In reaching this decision, the panel had regard to Miss Tarlea's written response within the Incident Report Form dated 10 March 2017, Resident A's Care Plan dated 10 March 2017 and the witness statement of Witness 6.

The panel noted that in her written response in the incident report form dated 10 March 2017 Miss Tarlea wrote that she *'tried to clean his mouth with tissue'*. The panel also noted Miss Tarlea's response in the Investigation Notes dated 26 June 2017, namely her response to the following question:

Home 1 - *'So you put the tissue in his mouth?'*
Miss Tarlea - *'Yes'*

The panel had sight of Resident A's care plan and noted the following:

'[Resident A] is known to put tissue in his mouth to help remove sputum from it and he can be left with tissue on his tongue or teeth. This is to be discouraged as he has a high risk of choking and it's not pleasant to have tissue in his mouth.'

The panel found that Miss Tarlea used tissue to clean Resident A's mouth which was contrary to the care plan. It therefore found this charge proved.

The panel also considered that the inappropriateness of putting a tissue in Resident A's mouth was exacerbated by the fact that he was already at a high risk of choking.

Charge 3.c

That you, a registered nurse, working at Maumbury Care Home:

3. Provided inappropriate care to Resident A when he was choking in that you:

c. Did not call 999 immediately when Resident A had difficulty breathing

This charge is found proved

In reaching this decision the panel had regard to the Incident Report form dated 10 March 2017 and the witness statement of Witness 5 and Witness 6.

The panel noted Miss Tarlea's written statement in the Incident Report Form dated 10 March 2017 in which she stated that she put tissue in Resident A's mouth and used the suction machine before dialling 999.

The panel had regard to the witness statement of Witness 6, in particular the following:

'[Miss Tarlea] then recorded in her statement [PRIVATE] that when she re-entered the room [Resident A] had phlegm in his mouth and was struggling to breathe, at which point she put tissue in his mouth. When [Miss Tarlea] she seemed to focus on the fact that he had phlegm in his mouth. What she should have noticed as a trained nurse was that he was struggling to breathe so she should immediately have put him in the recovery position and sought help by dialling 999…

[…]

Putting someone in the recovery position is basic life support training which as a nurse you are obliged to be competent in.'

The panel found that Miss Tarlea did not call 999 immediately when Resident A had difficulty breathing, rather that she put tissue in his mouth and attempted to use a suction machine. It considered that these actions prevented Miss Tarlea immediately putting Resident A in the recovery position and seeking emergency assistance by dialling 999. The panel therefore found this charge proved.

Charge 4.a

That you, a registered nurse, working at Maumbury Care Home:

4. Did not appropriately manage Resident B's medication in that:

a. On 7 March 2017 you created a PRN Medication Care Plan for Morphine sulphate for Resident B and did not record the time interval between doses;

This charge is found proved.

In reaching this decision the panel had regard to Resident B's As Required (PRN) Medication Care Plan, Home 1's Medication Management and Policy Guidance and the witness statement of Witness 4.

The panel had sight of Resident B's PRN Medication Care Plan and it noted that Miss Tarlea created on 7 March 2017. The panel also noted that Miss Tarlea did not record the time interval between doses of Morphine Sulphate.

The panel had regard to the witness statement of Witness 4 in which she stated the following:

'I attach the Morphine Care Plan as Exhibit [PRIVATE]. This states that [Resident B] could be given up to two doses a day of morphine but it does not state the time interval between doses. It was important that this information was included so that

the two doses were not given too close together, causing a risk of overdosing for [Resident B].'

The panel had regard to the Medication Management and Guidance which states that PRN medication written instructions need to include the minimum time intervals between doses.

Having regard to all of the above, the panel found this charge proved. The panel also found that Miss Tarlea did not appropriately manage Resident B's medication in not recording the minimum time between doses as there is a potential risk of an overdose.

Charge 4.b

That you, a registered nurse, working at Maumbury Care Home:

4. Did not appropriately manage Resident B's medication in that:

b. On 7 June 2017 you did not ensure the prescribed eye ointment was administered to Resident B;

This charge is not proved

In reaching this decision the panel had regard to the shift rota for 7 June 2017, the witness statement of Witness 2, Witness 3 and the Safeguarding Enquiry Report for Resident B

The panel noted that on 5 June 2017 Resident B was prescribed eye ointment to be administered four times a day on 7 June 2017.

The panel had sight of the rota at Home 1 and noted that Miss Tarlea and another registered nurse were on duty on 7 June 2017.

The panel had regard to the Safeguarding Enquiry Report for Resident B in which the following was noted in the findings of enquiry:

> *'Eye ointment was prescribed for [Resident B] on the 05/06/17 to be given 4 x a day for an eye infection. This arrived on the 06/06/17 and was given once that evening, once on the 07/06/17 at lunchtime and 4 x daily from the 08/06/17 to the 16/06/17 – when it is recorded 'course complete.'*

The panel noted that there was another registered nurse on duty on 7 June 2017. The panel did not have sight of Resident B's MAR Chart, or any evidence to enable it to establish whether Miss Tarlea was specifically assigned to care for Resident B on 7 June 2017 and therefore required to ensure that the eye ointment was administered to Resident B. The panel therefore concluded that the NMC has not discharged its evidential duty. Accordingly, the panel found this charge not proved.

Charge 5.

That you, a registered nurse, working at Maumbury Care Home:

> 5. Did not arrange a continence assessment for Resident B;

This charge is found proved.

In reaching this decision the panel had regard to Home 1's Continence Care Policy and Management Guidance and the witness statement of Witness 4.

The Continence Care Policy and Management Guidance in respect of continence assessment stated:

> *'Senior Health and Social Care staff (including registered nurses in Care Homes with nursing) must:*

- *Ensure all assessments are up to date and reviewed*
- *Ensure a current, accessible plan of care is in place and accessible to meet a person's individual continence care needs*
- *Carry out screening where possible to include urinalysis and report the findings to the medical practitioner if required*
- *Ensure timely referral to continence advisory service or medical practitioner'*

The panel also had regard to the witness statement of Witness 4 in which the following is stated:

> *'Generally a junior nurse would not attend a review meeting but if a junior nurse had attended the meeting then they would have passed the notes on to [Witness 10] to arrange a continence assessment. This meant that ultimately the responsibility for arranging the assessment lay with [Witness 10] in these circumstances.'*

While the panel noted that the policy stated that timely referrals were also the responsibility of a registered nurses in care homes, the panel noted Witness 4's witness statement, that it was ultimately the responsibility of Witness 10. Nevertheless, the panel found this charge proved on the basis that it is factually correct that Miss Tarlea did not arrange a continence assessment, whether she had a duty to will be considered at the next stage.

Charge 6.a

That you, a registered nurse, working at Maumbury Care Home:

6. Did not safely manage Resident B's skin integrity in April 2017 in that you:

a. Did not escalate a deterioration in Resident B's skin;

This charge is found proved.

In reaching this decision the panel had regard to Home 1's Tissue Viability Policy, the staff rota at Home 1, The Safeguarding Adults – Enquiry Report in relation to Resident B and the witness statements of Witness 3 and Witness 4.

The panel noted that the Tissue Viability Policy outlines that registered nurses are responsible for the management of wounds and pressure area care.

The panel had regard to the witness statement of Witness 3 in which the following is stated:

> '*The first reference we could find in [sic] of this concern were notes made on 21 April 2017, where there was a comment which stated in the medical section of Multi-Professional Visit Form notes, "urgent visit requested due to extensive sweat/fungal rash covering most of the torso. Area wet, red and exudate, body map done, rash now infected. To have antibiotics and anti-fungal medication. Will send prescription to Boots."*

The panel had regard to the witness statement of Witness 4 in which the following is stated:

> *'…I can see from the Daily Care Records for April 2017 (which I am unable to exhibit because I do not have access to these), which are outlined in [the Safeguarding Adults – Enquiry Report]… on 10 April the nurse on duty was made aware of [Resident B's] sore skin under her breasts… she recorded that "the nurse is aware"…*
>
> *[…]*
>
> *…I can see on 11 April that the skin is recorded as being "very sore underneath breasts". This is the point at which the nurse on duty should have started to manage the skin better as the notes from this point onwards continue to state that the skin is still sore (12 and 13 April). It was the responsibility of the nurse on duty on 11 April*

to take action. Leaving the wound to get worse until it was oozing pus on 16 April, as recorded in the Multi Professional Record…'

The panel noted that the shift rotas indicate that Miss Tarlea worked on 11 April, 12 April, 15 - 20 April, 25-26 April, 29-30 April 2017. The panel also noted that Miss Tarlea was the only registered nurse on 11, 15, 16, 18, 19, 25, 29 and 30 April 2017. Having regard to the written statement of Witness 4, the panel noted that Miss Tarlea was the only registered nurse on duty at Home 1 on 11 April 2017 and she did not escalate a deterioration in Resident D's skin. Furthermore, the panel noted that Miss Tarlea worked a number of shifts after 11 April 2017 and did not escalate a deterioration in Resident B's skin. Accordingly, the panel found this charge proved.

In respect of the stem of the charge, the panel considered that in not escalating a deterioration in Resident B's skin, it placed her at risk of harm. The panel therefore concluded Miss Tarlea did not safely manage Resident B's skin integrity.

Charge 6.b

That you, a registered nurse, working at Maumbury Care Home:

6. Did not safely manage Resident B's skin integrity in April 2017 in that you:

b. Did not ensure a body map was completed or photograph was taken or escalate the absence of a body map / photograph;

This charge is found proved.

In reaching this decision the panel had regard to Home 1's Tissue Viability Policy, the staff rota at Home 1, The Safeguarding Adults – Enquiry Report in relation to Resident B and the witness statements of Witness 4.

The panel noted that Home 1's Tissue Viability Policy stated:

‘Any skin changes should be documented/recorded immediately including a detailed description of what is observed and any action taken. Photographs can be taken of any wound to be kept with the record, subsequent photographs will aid evidence of healing or deterioration.’

The panel had regard to the Safeguarding Adults – Enquiry Report and the witness statement of Witness 4. It noted that Miss Tarlea did not ensure a body map was completed or photograph was taken or escalate the absence of a body map/photograph in April 2017. The panel therefore found this charge proved.

Having regard to the stem of the charge, the panel determined that in not following Home 1’s Tissue Viability Policy Miss Tarlea did not safely manage Resident B’s skin integrity in April 2017.

Charge 6.c

That you, a registered nurse, working at Maumbury Care Home:

6. Did not safely manage Resident B’s skin integrity in April 2017 in that you:

c. Did not ensure sorbaderm cream was applied twice a day, or in the alternative that application was recorded;

This charge is found proved.

In reaching this decision the panel had regard to Resident B’s Topical Medicines Application Record, Home 1’s Tissue Viability Policy and the staff rota at Home 1.

The panel had sight of Resident B’s Topical Medicines Application Record which included an entry was made by Miss Tarlea on 1 April 2017 which stated that sorbaderm barrier cream is to be applied to broken/dry skin twice a day. The panel noted that the application of the cream could be delegated to care assistants. However, it was Miss Tarlea’s

responsibility to ensure that any delegated tasks are carried out appropriately and signed for. In creating the record, Miss Tarlea should have ensured that her directions were being adhered to by other staff. The panel therefore found this charge proved.

In relation to the stem of the charge, the panel determined that in not ensuring that the cream was applied to Resident B's skin twice daily, Miss Tarlea did not safely manage Resident B's skin integrity in April 2017.

Charge 7.a

That you, a registered nurse, working at Maumbury Care Home:

7. Did not manage Resident C's pain appropriately in that you:

a. Did not record and/or administer Oramorph when changing their sacral sore dressings on 1 June 2017;

This charge is found not proved.

In reaching this decision the panel had regard to Resident C's Wound Care Chart, Resident C's MAR Chart, the witness statement of Witness 2 and Home 1's staff rota.

The panel had sight of Resident C's MAR chart in which it stated that on 25 May 2017 morphine sulphate oral was prescribed. It is also recorded that it should be administered to Resident C *'prior to dressings'*.

The panel also had sight of Resident C's Wound Care Chart and noted that it is recorded that there was pain at dressing change but there was no record on the MAR Chart of Oramorph being administered prior to the dressing being changed on 1 June 2017. The panel noted the statements of both Witness 2 and Witness 3 stated that when Miss Tarlea was asked why Oramorph had not been administered prior to dressings being changed,

she replied that it was '*potentially her clinical lead (Witness 10)'* who had changed the dressings.

The panel was provided with no further evidence that would allow it to reach an informed decision regarding the identity of the individual who carried out the change of Resident C's dressing on 1 June 2017.

Having regard to all of the evidence before it, the panel could not safely conclude on the balance of probabilities that it was Miss Tarlea who changed Resident C's dressing on 1 June 2017. The panel therefore found this charge not proved.

Charge 7.b

That you, a registered nurse, working at Maumbury Care Home:

7. Did not manage Resident C's pain appropriately in that you:

b. Did not complete a pain chart to assess the resident's pain;

This charge is found proved.

In reaching this decision the panel had regard to Home 1's guidance on Pain Assessment for People with Cognitive Impairment (PAPCI), the Safeguarding Enquiry Report for Resident C and the witness statement of Witness 4.

The panel had regard to the witness statement of Witness 4 in which she stated the following:

'I can see that [Miss Tarlea] stated that [Resident C] did not need the paracetamol but as [Resident C] could not communicate and no pain chart was used to assess the level of pain she was in…'

Having regard to the PAPCI the panel determined that a pain assessment for Resident C should have been carried out but it was not. Accordingly, the panel found this charge proved.

Charge 7.c

That you, a registered nurse, working at Maumbury Care Home:

7. Did not manage Resident C's pain appropriately in that you:

c. On 27 May 2017 did not administer paracetamol;

This charge is found proved.

In reaching this decision the panel had regard Home 1's shift rota, Resident C's MAR Chart and the witness statement of Witness 3.

The panel had sight of Resident C's MAR Chart in which it is recorded that paracetamol was prescribed. It is recorded that one tablet should be administered four times a day. The panel noted that on 27 May 2017 no paracetamol was administered to Resident C.

The panel noted that Miss Tarlea was on duty on 27 May 2017.

The panel had sight of Witness 3's witness statement in which she stated the following:

> *'[Miss Tarlea] was the nurse on duty on the day I visited [Resident C], so I asked her why [Resident C] had not been given her paracetamol four times per day as prescribed. [Miss Tarlea] told me that [Resident C] did not appear to be in pain and she felt that four times a day was too much paracetamol to give her. She stated that [Resident C] "does not need this high amount".'*

In the light of all of the evidence before it the panel determined that it was more likely than not that Miss Tarlea did not administer paracetamol to Resident C on 27 May 2017. Accordingly, the panel found this charge proved.

In respect of the stem of this charge, the panel was of the view that in not administering paracetamol as it had been prescribed, Miss Tarlea did not manage Resident C's pain appropriately.

Charge 7.d

That you, a registered nurse, working at Maumbury Care Home:

7. Did not manage Resident C's pain appropriately in that you:

d. Did not discuss the paracetamol medication with their GP before varying the frequency of the dose;

This charge is found proved.

In reaching this decision the panel had regard to Resident C's MAR Chart, Home 1's Medication Management Policy and Procedures and the witness statement of Witness 3.

The panel noted that Home 1's Medication Management Policy and Procedures stated:

'In Care Homes with Nursing, nursing staff are not designated as nurse prescribers, they too will seek advice from the person's GP or relevant health care professional.'

The panel had regard to the witness statement of Witness 3:

'[Miss Tarlea] was the nurse on duty on the day I visited [Resident C], so I asked her why [Resident C] had not been given her paracetamol four times per day as prescribed. [Miss Tarlea] told me that [Resident C] did not appear to be in pain and

she felt that four times a day was too much paracetamol to give her. She stated that [Resident C] "does not need this high amount".'

The panel noted that there was no evidence to suggest that Miss Tarlea had discussed reducing the dosage of paracetamol to be given to Resident C with a GP. Furthermore, the panel had regard to Miss Tarlea's response to Witness 3, that she was of the view that Resident C did not need the prescribed dosage of paracetamol. The panel therefore concluded that on the balance of probabilities it is more likely than not that Miss Tarlea did not discuss the paracetamol medication with the GP before varying the frequency of the dose. Accordingly, the panel found this charge proved.

Having regard to the stem of this charge, the panel concluded that Miss Tarlea, in not following Home 1's Medication Management Policy and Procedures, did not manage Resident C's pain appropriately.

Charge 7.e

7. Did not manage Resident C's pain appropriately in that you:

e. On 28, 30 and 31 May 2017 did not administer paracetamol at the frequency directed;

This charge is found proved.

In reaching this decision the panel had regard to Home 1's shift rota, Resident C's MAR Chart and the witness statement of Witness 3.

The panel had sight of Home 1's shift rota and noted that Miss Tarlea was working on 28, 30 and 31 May 2017. The panel also had sight of Resident C's MAR Chart which for 28, 30 and 31 May 2017. It noted that paracetamol was not given four times on the dates in question.

The panel had regard to the witness statement of Witness 3 (as set out in charges 6.c.and 6.d.) noting Miss Tarlea's opinion that Resident C did not require four doses of paracetamol as prescribed. In the light of all of the evidence before it, the panel found this charge proved.

In respect of the stem of this charge, the panel was of the view that in not administering paracetamol as it had been prescribed, Miss Tarlea did not manage Resident C's appropriately.

Charge 8

That you, a registered nurse, working at Maumbury Care Home:

> 8. Did not escalate or ensure that the tissue viability and wound care plan was updated and/or complete a body map between 30 January 2017 and 3 April 2017 for Resident C;

This charge is found not proved.

In reaching this decision the panel had regard to Resident C's Tissue Viability and Skin Integrity Care Plan, Tissue Viability Service Patient Report dated 30 January 2017 and Wound Care Chart. It also had regard to the witness statement of Witness 2.

The panel noted that Resident C's Tissue Viability and Skin Integrity Care Plan had been updated on a number of occasions between 25 September 2016 and 3 April 2017. The panel was of the view that for a tissue viability nurse to visit and assess Resident C, there had to have been some escalation by Miss Tarlea or one of her colleagues. The panel therefore found this charge not proved.

Charge 9

That you, a registered nurse, working at Maumbury Care Home:

9. Created topical medication application records for dermal lotion/cream and Medihoney for Resident C but did not ensure this was being applied, or in the alternative ensure a record of application was kept, during the month of May 2017;

This charge is found proved.

In reaching this decision the panel had regard to the shift rota at Home 1 around the time in question, Resident C's Topical Medicines Application Record dated 1 May 2017, and Safeguarding Adults – Enquiry Report. It also noted witness statement of Witness 2 and Witness 3.

The panel noted that the shift rota at Home 1 which covered May 2017 showed that Miss Tarlea worked a number of shifts during the month of May.

The panel had sight of the Safeguarding Adults – Enquiry Report, in particular, the following:

> *'[Resident C] is prescribed Medihoney cream prescribed 2 x daily this has not been given as prescribed with none having been given in the mornings on the 1-4th of May, the 18-20th, 23-24th, 28th to the end of the month. The afternoon/evening Medihoney was not signed off on the 1-4th, 5-6th 14th, 17th-19th, 22-23rd, 27th to the end of the month. Please note all dates are inclusive.*
>
> *The Dermol soap substitute has not been used on the 1-8th 16-20th, 23-24th, 27-28th 30th onwards – please note that this should be being used for all bed baths as a soap substitute. Dermol cream was also not fully filled in.'*

The panel also had sight of Resident C's Topical Medicines Application Record dated 1 May 2017 which was created by Miss Tarlea. The panel noted that the record showed 10 days in May when the dermal lotion/cream was either not used or not recorded. Miss Tarlea was the nurse who created these records and so, for the days she was on duty,

had a responsibility to check that her directions were being carried out as delegated. The panel therefore found this charge proved.

Charge 10

That you, a registered nurse at Queen Charlotte Nursing Home:

> 10. On 25 December 2017, updated Resident D's care plan and did not ensure there were clear instructions in relation to medication administration;

This charge is found proved.

In reaching this decision the panel had regard to Resident D's Care Plan, Resident D's Daily Notes and the witness statement of Witness 2.

Having had sight of Resident D's care plan, the panel noted that Miss Tarlea had identified the degree of risk (extreme), had noted broadly the precautions to be followed and had referred directly to the MAR Chart and Home 2's Medication Policy. However, the panel noted that Miss Tarlea documented that paracetamol was to be administered PRN, and when reviewing the MAR chart on 25 December 2017, it noted that Paracetamol is recorded as being prescribed to be administered four times a day. The panel therefore found this charge proved.

Charge 11

That you, a registered nurse at Queen Charlotte Nursing Home:

> 11. On 16 January 2018, did not administer paracetamol to Resident D;

This charge is found proved.

In reaching this decision the panel had regard to Resident D's drug chart for 16 January 2018.

The panel had sight of Resident D's drug chart for 16 January 2018 and it noted that, while there is evidence that Miss Tarlea was on duty on that date, she did not administer paracetamol to Resident D according to his drug chart. The panel therefore found this charge proved.

Charge 12.a

That you, a registered nurse at Queen Charlotte Nursing Home:

12. On 18 January 2018:

a. Did not record how Resident D's pain levels should be assessed;

This charge is found proved.

In reaching this decision the panel had regard to Resident D's Daily Notes and the witness statement of Witness 8.

It noted that Witness 8 stated:

> *'[Resident D] was not able to communicate verbally that she was in pain and as such I would expect that an Abbey Pain Tool would be used for her. An Abbey Pain Tool is used for residents at the Home who cannot communicate that they are in pain. This enables staff to use a list of questions which prompt staff to asses[sic] a resident's body language to try to indicate whether they are in pain. I don't think that the Abbey Pain Tool was completed for [Resident D].'*

The panel had sight of Resident D's daily notes for 18 January 2018 and it noted that there was no record of how Resident D's pain levels should be assessed. The panel had no

evidence before it to confirm that an Abbey Pain Tool had been created for Resident D. Further, there was no entry in Resident D's nursing record to indicate that pain levels had been assessed. It therefore found that on the balance of probabilities it is more likely than not that Miss Tarlea did not record how Resident D's pain levels should be assessed. Accordingly, the panel found this charge proved.

Charge 12.b

That you, a registered nurse at Queen Charlotte Nursing Home:

12. On 18 January 2018:

b. Did not update Resident D's care plan to show that morphine had been prescribed by the doctor;

This charge is found proved.

In reaching this decision the panel had regard to Resident D's Safeguarding Adults – Enquiry Report, Prescription Details and Care Plan.

The panel noted that Resident D's prescription of morphine was written on 18 January 2018, however, it was not received at Home 2 until after 18 January 2018. The panel determined that it would have been inappropriate for Miss Tarlea to record the prescription in Resident D's care plan before it had arrived at Home 2 and it is available to use. However, factually, Miss Tarlea did not update Resident D's care plan to show that morphine had been prescribed by the doctor on 18 January 2018.

The panel noted the way in which the charge was framed that Miss Tarlea did not update Resident D's Care Plan to show morphine was prescribed as a matter of fact. The panel concluded that Miss Tarlea did not update Resident D's care plan to show that morphine was prescribed by the doctor. The panel found this charge proved on the basis that it is factually correct that Miss Tarlea did not update Resident D's care plan to show that

morphine had been prescribed by the doctor, whether she had a duty to will be considered at the next stage.

Charge 13

That you, a registered nurse at Queen Charlotte Nursing Home:

> 13. On 27 January 2018, did not ensure morphine was administered to Resident D when you noted they were painful when touched;

This charge is found proved.

In reaching this decision the panel had regard to Resident D's Patient Records and MAR Chart.

The panel had sight of Resident D's drugs chart and it noted that morphine was prescribed as PRN medication so it could be given to her if she was experiencing pain. The panel noted that it had been recorded in Resident D's notes that she was in pain when touched on 27 January 2018. It noted that Miss Tarlea had made other entries on Resident D's record on 27 January 2018 so was satisfied that she was on duty that day. The panel had regard to Resident D's MAR Chart and it noted that no morphine was administered on 27 January 2018. The panel therefore found this charge proved.

Charge 14

That you, a registered nurse at Queen Charlotte Nursing Home:

> 14. On 27 January 2018, when updating Resident D's care plan in respect of nutrition, did not ensure there was an explanation as to why a pureed diet was recommended when Resident D was at risk of choking and/or why this was contrary to the SALT recommendation;

The panel found this charge not proved.

In reaching this decision the panel had regard to Resident D's Care Plan in respect of nutrition and Patient Records. It also had regard to the witness statement of Witness 2 and Witness 8.

The panel noted that Resident D's documentation indicates that she was at a risk of choking following an assessment that took place on 18 July 2017. The panel has not seen a copy of this assessment.

The panel had regard to the witness statement of Witness 2 and noted that on 2 January 2018 there was a further Speech and Language Therapist (SALT) assessment in relation to Resident D's feeding. The recommendations from this assessment were sent to Home 2 in a letter dated 26 January 2018, which was received by Home 2 in February 2018. The panel noted that this letter was not available in Home 2 until after the date specified in the charge.

The panel noted that the following was recorded in Resident D's 'MUST' (Malnutrition Universal Screening Tool) requirements dated 11 December 2017 by Witness 8:

'[Resident D] has her foods puree'd and fluids thickened to stage 1'

The panel noted that Witness 8 did not explain why a pureed diet was recommended when Resident D was at risk of choking and/or why this was contrary to the SALT recommendation.

The panel could not establish that Miss Tarlea was solely responsible for providing an explanation as to why Resident D's food was to be pureed, rather than pre-mashed as recommended. Further, as the letter dated 26 January 2018 was not received by Home 2 until February 2018, the panel had no evidence before it to show that Miss Tarlea would have been aware of the contents of this letter prior to February 2018.

The panel therefore found this charge not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Tarlea'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 Miss Tarlea's suitability to remain on the register unrestricted.

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, Miss Tarlea's fitness to practise is currently impaired as a result of that misconduct.

NMC written representations on misconduct

The panel had regard to the following written submissions contained within the NMC's statement of case:

> *'The Miss Tarlea's [Miss Tarlea] actions and omissions can be properly characterised as multiple, serious acts over a prolonged period of time at two different nursing homes. This is taken in the context of an unblemished career.*
>
> *The Miss Tarlea's actions also represent a significant departure from the principles of safe and effective care, including serious concerns in respect of medication administration, record keeping and escalation.*

The Miss Tarlea's conduct fell far below the standards to be expected of nurses and a finding of misconduct must necessarily follow.'

NMC written representations on impairment

The panel had regard to the following written submissions contained within the NMC's statement of case:

'Impairment needs to be considered as at today's date, i.e. whether the Miss Tarlea's [Miss Tarlea] fitness to practise is currently impaired.

The questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) instructive. Those questions as are relevant in this case were:

a. has [the Miss Tarlea] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or
b. has [the Miss Tarlea] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or
c. has [the Miss Tarlea] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or
d. […]

The Miss Tarlea's actions placed Residents A, B, C and D at serious, unwarranted risk of harm through failing to provide safe care, failure to provide medication and failure to keep records.

The Miss Tarlea's actions have brought the profession into disrepute. The public, quite rightly, expects Miss Tarleas, to be individuals who practise safely. The reputation of the profession requires that the public have no reason to think that this expectation may be misplaced.

The provisions of the Code invoked constitute fundamental tenets of the profession and the Miss Tarlea's actions have clearly breached these in so far as they relate to safe care, medication management and record keeping.

With regard to future risk it may assist to consider the comments of Silber J in Cohen, namely, whether the misconduct is easily remediable, whether it had in fact been remedied and whether it is highly unlikely to be repeated.

The Miss Tarlea's insight is very limited. She appears to accept the concerns in relation to Resident A at a local level. However, there is no evidence of any insight in relation to the other concerns. The concerns in this case relate to basic nursing skills.

You [the panel] will of course balance this against the circumstances at each care home, where there appeared to be contextual concerns in relation management.

There is no evidence of remediation or further training having been completed and the Miss Tarlea went from one nursing home to a further nursing home and there was a repeat of the problems. There is a clear risk that the Miss Tarlea will repeat and commit similar misconduct in the future. A finding of impairment is required to protect the public.

The Miss Tarlea actions are also so serious that a finding of current impairment is required in order to maintain public confidence in the professions and to uphold proper professional standards.'

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: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code). It accepted the advice of the legal assessor who referred the panel to *Roylance v GMC (No 2)* [2000] 1 A.C. 311 and *Council for Healthcare*

Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin).

The panel looked at each of the charges found proved individually and cumulatively. The panel considered that, with the exception of charge 12b, all the charges found proved amounted to serious misconduct and to the following breaches of the Code:

'1 - Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 Treat people with kindness, respect and compassion

1.2 Make sure you deliver the fundamentals of care effectively

1.4 Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

3 - Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.3 Act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 Act as an advocate for the vulnerable, challenging poor practice […] relating to their care

6 - Always practise in line with the best available evidence

To achieve this, you must:

6.2 Maintain the knowledge and skills you need for safe and effective practice

7 - Communicate clearly

To achieve this, you must:

7.2 Take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.3 Use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

7.4 Check people's understanding from time to time

8 - Work co-operatively

To achieve this, you must:

8.3 Keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.6 Share information to identify and reduce risk

10 - Keep clear and accurate records relevant to your practice. This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 Complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

10.2 Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

To achieve this, you must:

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

13 - Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 Make a timely referral to another practitioner when any action, care or treatment is required

13.3 Ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.5 Complete the necessary training before carrying out a new role

15 - Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 Only act in an emergency within the limits of your knowledge and competence

15.2 Arrange, wherever possible, for emergency care to be accessed and provided promptly

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

To achieve this, you must:

16.2 Raise your concerns immediately if you are being asked to practise beyond your role, experience and training

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

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

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'

The panel acknowledged that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Miss Tarlea's failures were serious and that all the charges found proved (with the exception of charge 12b), both individually and collectively, amounted to serious misconduct. It noted that the wide-ranging concerns related to the management of medical emergencies, the safe management and administration of medication, the appropriate management of pain and record keeping. The panel considered that Miss Tarlea's failings were multiple and related to basic nursing care. Further, the failings took place over a protracted period in two care homes and resulted in actual and potential harm being caused and four separate referrals to the NMC.

The panel considered that Miss Tarlea's conduct at charges 2a and 2c amounted to serious misconduct. It noted that Resident A was a vulnerable resident who was caused actual harm as a result of Miss Tarlea's actions. The panel considered that Miss Tarlea had failed to demonstrate essential nursing and life support skills.

The panel considered that Miss Tarlea's actions at charges 3a, 3b and 3c amounted to serious misconduct. It was of the view that using a suction machine without training, and subsequently using the wrong technique to do so, is a serious matter. The panel considered that all registered nurses have a fundamental responsibility to know how to use emergency equipment. It noted that using a tissue to clean his mouth was not only inappropriate but was explicitly identified as a risk to be avoided in Resident A's care plan, yet Miss Tarlea had done so. The panel considered that Miss Tarlea had taken inappropriate action by not putting Resident A in the recovery position and calling the emergency services. Similarly, the panel considered that to not call 999 when Resident A was experiencing difficulty breathing to be a failing of basic life support skills. It noted that there was also a specific policy in place to deal with hypoglycaemic patients that Miss Tarlea did not follow. The panel considered that Miss Tarlea's actions in charges 3a, 3b and 3c gave rise to the potential risk of very serious harm.

The panel considered that Miss Tarlea's actions at charge 4a created the risk of Resident B being overdosed with a controlled drug and therefore amounted to serious misconduct.

The panel considered that Miss Tarlea's conduct at charge 5 would be less concerning if it was a standalone charge but that, when viewed in light of the other misconduct, amounted to a course of conduct occurring over a period of time thereby resulting in serious misconduct. It noted that there may well have been other staff present at the time of this incident but that this did not absolve Miss Tarlea, who was the nurse in charge, of ensuring that a continence assessment was done. The panel considered that Miss Tarlea's misconduct at charge 5 would have impacted on Resident B's dignity and wellbeing.

The panel considered that charges 6a, 6b and 6c amounted to serious misconduct. It considered that Miss Tarlea's misconduct in charge 6a, 6b, 6c may have caused an aggravation of Residents B's skin. It considered that her misconduct may have caused serious harm to Resident B. The panel considered that Miss Tarlea had not fulfilled her duty of ensuring that appropriate photographs were taken and body maps completed to monitor and track Resident B's skin breakdown. Similarly, it found that Miss Tarlea had not fulfilled her duty of ensuring that Resident B was administered their prescribed topical cream, which was an important aid in their recovery.

The panel considered that charges 7b, 7c, 7d and 7e amounted to serious misconduct and formed part of a pattern of poor pain management practice. It noted that Resident C was a vulnerable resident who was unable to indicate verbally that she was in pain. The panel noted that there were tools available to assess such a resident's pain but that Miss Tarlea had not utilised them. It considered that not assessing such a vulnerable resident's pain was of the utmost seriousness and amounted to misconduct. The panel noted that Resident C had been prescribed paracetamol four times daily, not PRN, but that she did not receive this prescription on the dates specified in charges 7c and 7e. The panel considered that Miss Tarlea was not in a position to deem that four times daily was '*too much'* without consulting the GP and that she had failed in her duty to ensure that prescribed medication was administered.

The panel considered that Miss Tarlea's conduct at charge 9 would be less concerning if it was a standalone charge but, when viewed with the other misconduct found, and in the context of other medication administration concerns, it was satisfied that charge 9 amounted to misconduct. The panel acknowledged that medication could be given by care assistants if delegated but considered that Miss Tarlea, as the nurse in charge, had the

ultimate responsibility to ensure that all prescribed medication was given. Similarly, in finding that charges 10 and 11 amounted to serious misconduct, the panel considered that Miss Tarlea had the responsibility to administer prescribed medication and follow a care plan and was not in a position to be amending any prescription as she was not trained as a nurse prescriber. It considered that these charges demonstrate a pattern of poor practice in relation to medication management.

The panel considered that charge 12a amounts to serious misconduct. It considered that not taking appropriate action when a vulnerable resident was in pain is of the utmost seriousness. The panel noted that there were pain assessment tools which Miss Tarlea should have used, but did not do so.

The panel considered that charge 12b did not amount to serious misconduct as it was not satisfied that Miss Tarlea had the duty to record in the care plan that morphine had been prescribed until the drug physically arrived at Home 2.

The panel considered that charge 13 amounted to serious misconduct and that not taking action when a vulnerable resident is displaying clear signs of pain is a failure of fundamental nursing care. It noted that morphine was prescribed PRN and that Miss Tarlea had recognised that Resident D was displaying signs of being in pain when touched.

The panel was of the view that the serious misconduct outlined above had caused actual harm in some instances and that only good fortune prevented further harm being caused in other instances. It noted that Miss Tarlea's actions also caused distress to patients' relatives.

Taking all the information into account, the panel concluded that Miss Tarlea's actions repeatedly fell significantly short of the conduct and standards expected of a registered nurse and amounted to serious misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be 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 *Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) …'

The panel determined that the first three limbs of the test are engaged in Miss Tarlea's case.

The panel noted that actual harm was caused and further residents were put at a real risk of significant harm as a result of Miss Tarlea's misconduct. It noted a pattern of poor medications management which had the potential for very serious harm. Further, vulnerable residents were left without pain relief as a result of Miss Tarlea's misconduct.

The panel considered that having departed so far from the standards expected of a registered nurse, and by breaching numerous provisions of the Code, Miss Tarlea had brought the profession's reputation into disrepute. It considered that a well-informed member of the public would be troubled to hear about Miss Tarlea's misconduct. Further, fellow practitioners would find Miss Tarlea's conduct wholly unacceptable.

The panel considered that Miss Tarlea's misconduct demonstrated a lack of regard for the dignity of residents of Home 1 and a general lack of care for residents of Home 2. Further, her actions in not taking appropriate pain relief measures could be perceived as cruel. It also considered that not following residents' care plans and administering prescribed medication demonstrated a lack of insight for the needs of residents of Home 1 and Home 2. Consequently, the panel determined that Miss Tarlea had breached fundamental tenets of the profession which should have been adhered to at all times. It considered that Miss Tarlea's failure to adhere to these is likely to result in members of the public losing confidence in the profession and the NMC as its regulator.

The panel noted that there were numerous serious and wide-ranging clinical errors identified. It had no current and relevant evidence before it to indicate that Miss Tarlea has

taken steps to sufficiently strengthen her practice. It noted that she has not engaged with the NMC in response to these concerns. Further, Miss Tarlea has not provided any references from any current employer or details of any recent training undertaken.

The panel was concerned that there is no evidence from Miss Tarlea to demonstrate any substantial remorse or insight into her actions. Miss Tarlea has not admitted any of the concerns at regulatory level nor has she recognised her shortcomings. Further, Miss Tarlea has not demonstrated any recognition of the impact of her misconduct on residents of Home 1 and Home 2 and their relatives, her colleagues or the reputation of the profession.

The panel is of the view that in the absence of any insight, remorse or strengthening of practice, and Miss Tarlea's abject non-engagement with the NMC, there remains a real risk of the misconduct being repeated. On the basis of all the information before it, the panel decided that there is a risk to the public if Miss Tarlea was permitted to practise without restriction. The panel therefore determined that a finding of current impairment on public protection grounds is necessary.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that Miss Tarlea's actions had brought the profession into disrepute and breached fundamental tenets of the profession. It considered Miss Tarlea's actions to have fallen significantly short of the standards expected of a registered nurse. The panel considered that a member of the public would be deeply troubled to hear of a nurse making repeated and serious errors. The panel therefore determined that a finding of impairment on public interest grounds is also required in order to maintain the reputation of the profession and to uphold the proper standards of conduct.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Miss Tarlea off the register. The effect of this order is that the NMC register will show that Miss Tarlea's name has been removed from 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.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 19 May 2021, the NMC had advised Miss Tarlea that it would seek the imposition of a 12 month suspension order, with a review, if it found Miss Tarlea's fitness to practise currently impaired. The panel had regard to the NMC's written submissions on sanction, which included:

> *"A 12 month suspension order with a review is the proportionate sanction in this case. It should be noted that that this is not a single incident of misconduct and the registrant has not shown insight. There is also a significant risk of the registrant repeating behaviour.*
>
> *Whilst there are some features of this case which suggest a striking off order may be appropriate, the concerns are largely clinical. As such, it may be thought that the Registrant's conduct is not fundamentally incompatible with continued registration and that the serious features of the case which would in other circumstances be suggestive of a striking off order can be appropriately recognised by the length of the suspension order, which should be for 12 months. A review is necessary given the public protection concerns."*

The panel accepted the advice of the legal assessor, who referred it to the Sanctions Guidance (SG), in particular, the guidance in relation to *"serious concerns which could result in harm to patients if not put right".*

Decision and reasons on sanction

Having found Miss Tarlea's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. In particular, the panel assessed its findings of fact and its determination on misconduct and impairment by reference to the guidance in the SG on *"serious concerns which could result in harm to patients if not put right".* The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- No engagement from Miss Tarlea with the NMC;
- Miss Tarlea's conduct put residents at risk of actual and potential harm;
- Residents A, B, C and D were extremely vulnerable residents in care homes;
- Abuse of a position of trust;
- Miss Tarlea's pattern of misconduct occurred over a period of time, across two different care homes with numerous breaches of the Code;
- Lack of insight into failings;
- No evidence of remorse;
- No evidence of Miss Tarlea strengthening her practice.

The panel also took into account the following mitigating features:

- Level of experience of Miss Tarlea, only being on the NMC register for approximately 18 months;
- Previous good character;
- Culture of poor practice at both Home 1 and Home 2;
- Evidence of limited support and leadership within the Homes.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

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

The panel next considered whether placing conditions of practice on Miss Tarlea's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that conditions of practice could manage some of the risk in regard to Miss Tarlea's medication administration and record keeping. As Miss Tarlea has not engaged with the NMC process, there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel concluded that the placing of conditions on Miss Tarlea's registration would not adequately address the seriousness of this case and would not protect the public. The panel was of the view that the remaining charges found proved in this case were serious, repeated and happened within two care homes. The panel noted that residents were put at a real risk of harm by Miss Tarlea, and in two instances, actual harm. The panel agreed with the NMC's submissions on a conditions of practice order, and took into consideration Miss Tarlea's lack of insight, no evidence of remorse and no evidence of her strengthening her practice. Therefore, a conditions of practice order is inappropriate in this case.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel also noted that the Sanction Guidance states that a panel should also consider the following matters when considering a suspension order:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour*

The panel has found, in its prior determinations, that this was not a single instance of misconduct, rather it was multiple instances of misconduct over a period of time. The panel has also found, in prior determinations, that Miss Tarlea has shown no real insight into her failings and therefore there continues to exist a significant risk of her repeating her behaviour.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse and placed vulnerable residents at actual and potential risk of serious harm. The panel considered that the serious breaches of fundamental tenets of the profession evidenced by Miss Tarlea's actions is fundamentally incompatible with Miss Tarlea remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction and it would not satisfy the public interest in this case.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Miss Tarlea's actions, in relation to residents A and C, were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Miss Tarlea's actions were serious, as they relate to placing vulnerable patients at risk of actual and potential harm. The panel was of the view that to allow her to continue practising would also undermine public confidence in the profession and in the NMC as a regulatory body. This may cause the public to lose trust in nurses, and be reluctant to use health and care services.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Miss Tarlea's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

In making this decision, the panel carefully considered the written submissions from the NMC in relation to the sanction that the NMC was seeking in this case. However, the panel considered that the NMC's written submissions did not recognise the seriousness of Miss Tarlea's misconduct. The panel was of the view that a suspension order would not meet the public protection and public interest concerns raised in this case. Miss Tarlea's actions were very serious, as they related to her treatment of vulnerable patients over an extended period of time in two separate care homes. The panel further considered Miss Tarlea's lack of insight, remorse and engagement and there being no evidence of her strengthening her practice. The panel determined that Miss Tarlea's actions were not compatible with being on the register.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Miss Tarlea's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Miss Tarlea in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Miss Tarlea's own interest until the striking-off sanction takes effect.

Decision and reasons on interim order

The panel accepted the advice of the legal assessor.

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim

suspension order for a period of 18 months to ensure that an order is in place in case Miss Tarlea appeals this decision.

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

That concludes this determination.