Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Virtual Hearing

Monday 15– Friday 19 March 2021

Physical hearing

Monday 22 – Monday 29 March 2021

Monday 25 – Wednesday 27 October 2021

Monday 8 – Friday 26 November 2021

Tuesday 4 and Thursday 6 January 2022

Tuesday 3 – Friday 20 May 2022

Wednesday 11 – Friday 13 May 2022

Tuesday 17 May 2022

Name of registrant:	Jugdutt Dudhee
NMC PIN:	70F0400E
Part(s) of the register:	Registered Nurse – Mental Health RN3, Mental Health (31 July 1973)
Area of registered address:	Surrey
Type of case:	Misconduct
Panel members:	John Brookes (Chair, lay member) Deborah Hall (Registrant member) Beth Maryon (Registrant member)
Legal Assessor:	Graeme Henderson
Panel Secretary:	Catherine Acevedo
Nursing and Midwifery Council:	Represented by Leeann Mohamed, Case Presenter
Mr Dudhee:	Present by telephone and unrepresented

No case to answer:	Charges 9, 10, 1a in relation to schedule A1
Facts proved:	Charges 1a in relation to Schedule A6, A7, A9, A12, A18, A20, A21, A25, A27, A33, 1b, 2a in relation to Schedule B 8, B 10, B 14, B 15, B 23, B 24 2b, 5a in relation to Schedule D 1, D 2, D 3, D 4, D 5, D 6, D 7, D 9, D 12, 5b, 6a in relation to Schedule E 1, E 2, E 3, 6b, 7a, 7b, 7c, 8, 11
Facts not proved:	Charges 1a in relation to Schedule A 2, A3, A4, A5, A8, A10, A11, A13, A14, A15, A16, A17, A19, A22, A23, A26 A28, A29, A30, A31, A32, 2a in relation to B 1, B 2, B 3, B 4, B 5, B 6, B 7, B 9, B11, B12, B13, B16, B17, B18, B19, B20, B21, B22, 3a in relation to Schedule C 1, C 2, C 3, C 4, C 5, C 6, 3b, 4a, 4b, 5a in relation to Schedule D 8, D10, D11, 6a in relation to E 4, E 5, E6, E 7, E 8
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order – 18 months

Details of charge

That you, a Registered Nurse at Cheam Cottage ('the Home'):

1) *Failed to maintain / ensure an adequate standard of record – keeping / documentation was maintained in the Home:*

   a) *As set out in Schedule A;*
   b) *Generally;*

2) *Failed to document wounds, bruises and dietary needs appropriately or at all in relation to one or more residents and / or ensure that such documentation was undertaken by staff at the Home*

   a) *As set out in Schedule B;*
   b) *Generally;*

3) *Failed to prevent members of staff prewriting / inaccurately recording notes / records;*

   a) *In relation to one, or more, residents as set out in Schedule C;*
   b) *Generally;*

4) *Your conduct at any and / or all of charge 3 above was dishonest in that you:*

   a) *knew that staff had prewritten / inaccurately recorded notes / records;*
   b) *Knew that inaccurate record- keeping was taking place;*

5) *Failed to make necessary and / or timely referrals in relation to one, or more, residents and / or ensure that such referrals were made by staff:*

   a) *As set out in Schedule D;*
   b) *Generally;*

6) *Failed to have appropriate / due regard to the changing dietary / health needs of one, or more, residents and / or ensure that appropriate regard was had to such needs:*

   a) *As set out in Schedule E;*
   b) *Generally*

7) *On 9 May 2017:*

   a) *Failed to intervene when one, or more, members of staff shouted at Individual A who was enquiring about food being fed to a patient;*
   b) *Joined in with the events referred to in charge 7(a) above;*
   c) *Laughed at Individual A when she asked about the soup being provided to residents;*

8) *Your conduct at any and / or all of charge 7 above, took place in front of residents at the Home and/or was inappropriate;*

9) *Failed to ensure that correct procedures and protocols were carried out in relation to the use of controlled drugs at the Home;* ***(No case to answer)***

10) *Failed to ensure that the Deprivation of Liberty Safeguards ('DoLS') procedure was followed in relation to one, or more, residents;* ***(No case to answer)***

11) *Your conduct / failings at any and/or all of the charges referred to above resulted in a preliminary decision to advise all Local Authorities with placements to move residents out of the Home and/or the voluntarily closure of the Home, resulting in one, or more, residents having to be moved.*

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

SCHEDULE A		
	Resident	***Event***
1		*Failed to ensure that controlled drug checks were undertaken / recorded*
2	*A*	*The nutritional assessment of zero was incorrect as the resident was able to chew and swallow, albeit with difficulty*
3	*A*	*No adequate record of the resident's need for a halal diet*
4	*B*	*One, or more, documents in the residents file were blank / not completed*
5	*B*	*Person-centered / well- being documents were unsigned / undated*
6	*C*	*On 9 May 2017, the residents repositioning chart had not been updated since 6 am that morning*
7	*C*	*On 9 May 2017, the residents food chart had not been completed since lunch in respect of the residents fluid intake / as necessary*
8	*C*	*On 9 May 2017,the residents hourly observation chart had not been completed since 11am*
9	*C*	*The geriatric depression formulation was inaccurate and / or clinically inappropriate*
10	*C*	*No record in the care plan / daily notes relating to abnormal findings in relation to the residents body temperature between January 2016 and May 2017*
11	*C*	*No record in the care plan / daily notes relating to abnormal findings in the residents respiratory rate between January 2017 and May 2017*
12	*C*	*The daily care notes lacked detail / failed to address the residents condition / changing needs*
13	*C*	*The notes were inconsistent with the residents development of bed sores*
14	*C*	*The Care Plan did not provide sufficient detail relating to the type and use of the pressure relieving mattress*
15	*C*	*The Care Plan did not accurately reflect the concerns of the TVN*
16	*C*	*The Nutritional Care Plan dated 18 May 2016 did not contain reference to the dieticians recommendations / contained confusing information*
17	*C*	*No reference to the residents decreasing BMI / weight loss and / or nursing interventions to address such matters*

18	*E*	*Monthly dependency assessments carried out between January to May 2017 were not signed / dated and / or did not accurately reflect to residents needs*
19	*E*	*No record in the care plan / daily notes relating to abnormal findings in relation to the residents body temperature / respiratory rate between January 2017 and May 2017*
20	*E*	*The residents leg bag did not record when it had been set up*
21	*E*	*The residents conditions / care needs were not accurately reflected in the notes*
22	*F*	*At a review / inspection on 2 June 2017, the resident was recorded as both being at a high risk of falls and also at no risk at all*
23	*F*	*The nutritional screening assessment scored as '0' reflecting that the resident had no issues, whereas the resident was also 24recorded in the 'care and well-being section' as being thin, with a poor appetite*
25	*G*	*Staff amended the personal care assessment by adding an additional section stating that the patient had had no falls as well as recording conflicting evidence that the resident was at a higher risk of falling*
26	*G*	*No care plans / risk assessments / management plans were in place in relation to the residents diabetes*
27	*G*	*The geriatric depression scale formulation on 18 May 2017 was inaccurate due to the resident being cognitively impaired and / or clinically inappropriate*
28	*H*	*No care records completed / on file prior to 2016, despite the resident having moved into the accommodation in 2010*
29	*H*	*No daily care records completed / on file prior to 24 May 2017, despite the resident having moved into the accommodation in 2010*
30	*H*	*In June 2017, no explanation for an increase of a previous aggregate Waterlow pressure score of 14 / record of composite scores from 14 to 22*
31	*H*	*The Dependency Level Assessment Tool undertaken between January and May 2017 contained conflicting information when compared with the requirements of the residents care plan*
32	*H*	*No record of the residents normal / abnormal body temperature or breathing rate*
33	*H*	*Between 24 May 2017 and 16 June 2017, the residents notes lacked detail / appeared inconsistent with the appearance of the patient*

SCHEDULE B		
	Resident	***Event***

1		*As at 15 June 2017, no care plans / wound assessments in place for one, or more, residents*
2		*As at 16 June 2017, there were no set menus in place for the residents / any information in the kitchen to ensure consistency in diets for the residents*
3	*A*	*No adequate record / note that the resident should be on a halal diet*
4	*B*	*The resident's dislike of certain food*
5	*C*	*Documentation in relation to only one wound recorded, despite the TVN noting several areas of concern on 19 July 2017*
6	*C*	*No skin integrity checks / risk assessments in the residents file*
7	*C*	*Care plan failed to provide sufficient detail relating to the residents pressure relieving mattress / cushion*
8	*E*	*No wound care assessment / wound chart / care plan undertaken in relation to a pressure ulcer between 25 April 2017 and 30 May 2017*
9	*E*	*The wound documentation completed on 30 May 2017 was incomplete / inadequate in that it failed to record the size of the wound / type of wound / dressing required*
10	*E*	*Wound chart and care plan was not developed within a reasonable time following the TVN's identification of a pressure ulcer in April 2017*
11	*E*	*No supporting records as to how the residents Waterlow scores were calculated between January to June 2017*
12	*E*	*Inadequate documentation / no record of action taken in respect of the residents weight loss*
13	*E*	*Care Plan dated 12 January 2017 is too vague and incomplete*
14	*E*	*Records did not contain information regarding the residents meals being fortified / provision of supplements*
15	*F*	*No recent / updated body map / care plan recording bruises and marks on the arm of the resident*
16	*H*	*No adequate record / documentation relating to one, or more, wounds on the residents body*
17	*H*	*Wound assessment undertaken on 15 June 2017 lacked clarity as to whether the wound was on the residents right hip or foot*
18	*H*	*On 15 June 2017 individual assessments were not carried out in relation to sacrum and ankle wounds*
19	*H*	*As at 20 June 2015 / the time of a visit by the TVN, various wounds had not been documented.*
20	*H*	*Care plans for the residents pressure sores were vague and lacked detail / failed to identify nursing intervention on pain*
21	*H*	*Lack of daily review of the wounds recorded (including healing)*
22	*H*	*Having scored an aggregate score of 2 for the nutritional assessments undertaken between January and June 2017 suggesting unintentional weight loss, no record of action taken in relation to the weight loss*
23	*H*	*Care Plan lacked sufficient detail relating to the residents severe weight loss and reduction in BMI*

24	*H*	*Care plan lacked detail of whether additional nutritional supplements were required / the residents meals needed to be enhanced*

SCHEDULE C		
	Resident	***Event***
1	*A*	*On 9 May 2017, prior to 12:40, completed one, or more, residents notes in advance / for the entire day*
2	*B*	*On 9 May 2017, prior to 12:40, completed the residents notes in advance / for the entire day*
3	*D*	*On 9 May 2017, prior to 12:40, completed the residents notes in advance / for the entire day*
4	*Various*	*On 2 June 2017, prior to around 11 am, completed the residents daily notes*
5	*Various*	*On 8 June 2017, prior to around 11 am, completed the residents notes / medication administration*
6	*B*	*On 8 June 2017, completed the residents notes for the day prior to all necessary care having been provided / medication administered*

SCHEDULE D		
	Resident	***Event***
1	*A*	*A referral to the Challenging Behaviour Team following scores of A and B on 9 November 2016*
2	*B*	*A referral to a dietician / TVN / GP following concerns regarding the residents BMI*
3	*C*	*A referral to a dietician in February 2016 following a BMI of 14*
4	*C*	*A referral to a dietician from June 2016 onwards and in relation to the residents low BMI generally*
5	*D*	*A referral to a dietician / TVN / GP following the residents BMI being recorded as 16 on 28 April 2017*
6	*E*	*A referral to a GP following a pressure ulcer wound being noted on 25 April 2017*
7	*E*	*A referral to a dietician due to the residents low BMI*
8	*F*	*A referral to a dietician which was not made until 22 May 2017 in relation to the residents low BMI*
9	*H*	*A referral to a dietician following a low BMI in or around February 2016 / timeously*
10	*H*	*A referral to a dietician / new care plan following the resident having an aggregate score of 2 for nutritional assessments undertaken between January and June 2017*
11	*H*	*Prior to 20 June 2017, a referral to a TVN despite the resident having a number of wounds*

12	*H*	*A referral in relation to the residents normal / abnormal body temperature or breathing rate within the vital signs documentation between December 2016 and May 2017*

SCHEDULE E		
	Resident	***Event***
1	*A*	*The residents need for a halal diet*
2	*B*	*The residents dislike of vegetables and the fact that they continued to be fed such items*
3	*C*	*The residents care plan dated 18 May 2016 did not contain reference to the dieticians recommendations / the residents weight loss / and contained vague and insufficient information*
4	*E*	*The residents weight loss / sufficient detail regarding the residents diet / meal requirements / supplements*
5	*F*	*The residents need for a vegetarian diet / the recommendation by the dietician for cheese and cream to be added to the residents diet*
6	*H*	*The residents weight loss following and aggregate score of 2 for the nutritional assessments undertaken between January and June 2017 / generally*
7	*H*	*The residents needs for nutritional supplements / meal enhancements required*
8	*H*	*The residents skin deterioration*

Following the charges being read the chair asked if you objected to the charge on a point of law. You indicated that you did object.

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

It considered that the criticisms made of the charges were evidential issues that should be more properly explored at a later stage.

However, the panel considered that it should discuss the issue of the relevancy of a number of charges at this stage. It considered that it had an obligation to be proactive in assisting unrepresented registrants. It invited the legal assessor to

comment and then invited Ms Mohammad to address it on a number of sub charges which contained the same word. The NMC had added a sub-charge with a single word –"generally" after a number of more particular charges.

Having taken instruction from the NMC, Ms Mohammad indicated that the NMC were proposing on each of the sub-charges containing the word "generally" remaining. She submitted that you alone were charged using this wording as you were the manager in charge of the home at the material time. There were witness statements which talked about aspects of the home that were generally not satisfactory. She further submitted that this matter could be discussed again at the "no case to answer" and other stages.

The panel heard and accepted the advice of the legal assessor who referred to the case of *Gee v General Medical Council 1987 I WLR 564*. In that case the House of Lords indicated that a charge, together with the evidence should give "fair notice".

The panel considered that, on reading the charge, together with the evidence as a whole there was sufficient material with which you could mount a defence. There was no unfairness to you in answering these charges. For example you could seek to refute 1 (b) by providing examples of an adequate standard of record keeping or documentation. If, ultimately, the NMC were able to prove all of the charges set out in a particular schedule it would be possible for a panel to conclude that this aspect of your practise was generally inadequate.

In light of this, the panel determined to allow the charge to remain as it was.

Decision and reasons to adjourn

Ms Mohamed made an application under Rule 32 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ('the Rules') to adjourn the hearing.

Ms Mohamed informed the panel that the witness due to be heard today, Witness 7, had spoken to her. Ms Mohammed had discovered that there were 14 documents in the hearing bundle that the expert had not spoken to in his report. She requested that he should be asked to comment on them. He explained he was unable to give expert advice on documents that were only provided to him by the NMC on the morning that he was scheduled to give evidence. Witness 7 indicated that he would be unable to provide his expert opinion spontaneously and would need 3-4 weeks to complete a further report.

Ms Mohamed asked the panel to allow the NMC further time for the report to be completed by the witness and adjourn the hearing to a later stage when the report is available.

You told the panel that he has been waiting for a long time for these proceedings to take place and this has been detrimental to yourself and the other registrants.

The panel accepted the advice of the legal assessor. He referred the panel to Rules 32(1) and 32(4) and advised the panel to have regard to a number of factors when considering the application, including the public interest in the expeditious disposal of the case, inconvenience to witnesses or other parties, and fairness to the registrant.

The panel decided to allow the application to adjourn the hearing. It considered that the additional report would speak to a significant part of the NMC's case and in the absence of the report, there would be no purpose in proceeding with the hearing today.

While any delay in the disposal of a case is undesirable, the panel was of the view that it would be unfair to the registrants and the NMC not to adjourn today. Additionally, insisting on the expert giving his evidence today would be unfair on him. The panel's overriding concern is to protect the public and it was of the view that it had a duty to hear Witness 7's complete evidence. The panel was of the view that there was no realistic prospect of the case concluding in the remaining days allocated to it. Accordingly, a decision to adjourn would not have a material effect on the expeditious disposal of the case.

It therefore decided to accept the application to adjourn the hearing so that it may be relisted at a later date.

The panel was aware that Rule 32 (5) required it to consider making an interim order. It received no submissions from the NMC to suggest that the panel should impose such an order. It was of the view that, as no findings of fact had been made it would be inappropriate to impose one. It was the NMC's position that the public were adequately protected. Since such an order was not necessary for the protection of the public and it would also neither be in the public interest or the interests of the registrants.

This decision will be confirmed to you in writing.

Hearing Resumed 25 October 2021

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Dudhee was not in attendance and that the Notice of Hearing letter had been sent to Mr Dudhee's registered address by recorded delivery and by first class post on 28 September

2021. The Notice of Hearing letter had also been sent to Mr Dudhee's registered email address on 28 September 2021.

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

Ms Mohamed, 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.

In the light of all of the information available, the panel was satisfied that Mr Dudhee 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 Mr Dudhee

The panel next considered whether it should proceed in the absence of Mr Dudhee. It had regard to Rule 21 and heard the submissions of Ms Mohamed who invited the panel to continue in the absence of Mr Dudhee. She submitted that Mr Dudhee had voluntarily absented himself.

Ms Mohamed referred the panel to various telephone notes between Mr Dudhee and the NMC. A telephone note dated 8 October 2021 stated *"[Mr Dudhee] told me that he was given an eviction notice on Tuesday 5th October and will have 28 days to*

leave his property". A telephone note dated 7 October stated *"Registrant called to say his house is getting repossessed. He has filed for bankruptcy, he doesn't know where he will be living in the future... He said he wanted me to make a note of this and pass it on."* A telephone note dated 25 October 2021 stated *"I called Mr Dudhee this morning and asked him if he wants to participate in the hearing. He said there is not point and ended the call".*

Ms Mohamed also informed the panel that the NMC had not sent Mr Dudhee or the other registrants the transcript of the hearing with the notice. She submitted that it is a matter for the panel whether it would be fair to proceed without Mr Dudhee having received the transcript.

The panel has decided not to proceed in the absence of Mr Dudhee until he had received a printed copy of the transcript. In reaching this decision, the panel has considered the submissions of Ms Mohamed and the advice of the legal assessor.

The panel took into account that Mr Dudhee had previously been very engaged with the hearing proceedings. It noted that Mr Dudhee had informed the NMC that he was experiencing extremely difficult personal circumstances. The panel considered that it should give Mr Dudhee the opportunity to provide the panel with evidence of his personal circumstances and to be informed of his options at this hearing. The panel considered that it would be unfair to proceed with the hearing without the registrants having received or had the opportunity to read the transcripts.

In these circumstances, the panel has decided to adjourn the hearing until 27 October 2021, to allow Mr Dudhee the opportunity to reengage with proceedings and provide further information about his current circumstances, to allow the NMC to send printed copies of the transcript to all of the registrants and to give them the opportunity to read the transcript.

27 October 2021

On 27 October, the panel decided to adjourn the hearing until the 8 November 2021 until the NMC's final witness, Witness 7, is available to give evidence. Witness 7's evidence had to be rescheduled after the hearing did not proceed on 25 October 2021.

The panel was also informed that all the registrants had been sent printed copies of the transcript by recorded delivery but you had not yet received this.

You informed the panel of your personal difficulties including a Court order dated 5 October 2021.

Since the hearing was to be adjourned until 8 November 2021, the panel decided that it would not consider any possible application for an adjournment until then.

This decision will be confirmed to you in writing.

8 November 2021

At the resumption of the hearing on 8 November 2021, the panel was informed that the NMC had sent you the transcripts on two occasions by royal mail recorded delivery but they had not been delivered to him.

The panel decided that, in fairness to you, it would resume the hearing the following day on 9 November 2021, to give the NMC a further opportunity to send you the documents and for you to receive and read them. The panel was assured that these documents would couriered to you on the 8 November 2021.

9 November 2021

The hearing resumed on temporary telephone conference call due to technical difficulties with the video link.

On 9 November 2021, the panel was informed by Mr, on behalf of the NMC that Ms Mohamed had become suddenly unwell and was unable to act as case presenter today to address the panel either in person or virtually.

Mr Scott invited the panel to adjourn the hearing until 10 November 2021 to allow the NMC time to obtain more information about Ms Mohamed and whether she would be in a position to proceed with the hearing tomorrow.

Mr Scott was mindful that the NMC's case is complete other than for the evidence of Witness 7. Mr Scott submitted that in the time that has been afforded to him this morning he has not had the opportunity to familiarise himself with the case and to read the documentary evidence exhibited by Witness 7. Mr Scott submitted that and he is not in a position to progress the case today.

Mr Scott submitted that should Ms Mohamed be well enough tomorrow, the hearing can progress without his involvement. However, in the position that Ms Mohamed cannot proceed tomorrow, Mr Scott submitted that he will have had more time to prepare and be able to call Witness 7 who is available to give evidence tomorrow.

You informed the panel that you had received the documents couriered to you the previous day. You reminded the panel that it has been four years that he has not

been able to work, and these proceedings have gone on for too long. You said it is not right what the NMC are doing.

Registrant C agreed with your submissions.

The panel heard and accepted the advice of the legal assessor who referred it to Rule 32 of the Rules.

The panel decided that no injustice would be caused by a short adjournment to the following day.

The panel took into account that Witness 7 would be available on 10 November 2021 to give evidence and the NMC has a clear plan for progressing the case tomorrow and calling Witness 7.

The panel took into account the submissions from you and Registrant C that these proceedings have taken a long time and it empathised with their position.

However in the circumstances, the panel has decided to adjourn the hearing until 10 November 2021, to allow the NMC further time to plan how to progress the hearing in the eventuality that Ms Mohamed cannot present the case tomorrow. It considered that the NMC should be given time to prepare to call Witness 7, given the unexpected nature of the circumstances. This would also give further time for you to review the documents which you only received on 8 November 2021.

Wednesday 10 November

The panel heard evidence from the final NMC witness, Witness 7. Mr Scott closed the NMC's case. At the close of the NMC's case the legal assessor advised you and Registrant C who were present that they had the right to make an application for a finding of no case to answer. He indicated that it was likely that the panel would consider this issue on behalf of Registrant B who was absent.

Mr Scott on behalf of the NMC, made an application to adjourn the hearing to Monday 15 November 2021 before any potential application in relation to no case to answer was made.

Mr Scott submitted that he was in no position to respond on behalf of the NMC to an application of no case to answer. He submitted that the number of documents and the quantity of evidence the panel has heard could not be easily absorbed by anyone other than Ms Mohamed. He submitted that it would be unfair to the NMC to progress the hearing at this point.

Mr Scott informed the panel that Ms Mohamed continues to be unwell. Mr Scott submitted that Ms Mohamed should be in a position to resume the hearing on Monday and fully respond to any application of no case to answer that is made.

You and Registrant C agreed that it was inevitable that the case would be adjourned at this time and could not proceed without Ms Mohamed.

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

The panel considered that it would be unfair to the NMC for the hearing to proceed at this stage as the NMC was not in a position to proceed without Ms Mohamed who had more knowledge and understanding of the case.

The panel also considered that an adjournment until Monday 15 November 2021 would give both you and Registrant C time to prepare and consider any application of no case to answer in relation to any of the charges they face.

In the circumstances, the panel has decided to adjourn the hearing until Monday 15 November 2021 for Ms Mohamed to return and present the hearing.

Monday 15 November

Decision and reasons on application of no case to answer

At the close of the NMC's case the panel reminded itself that it could, of its own volition, raise the issue of whether there was a case to answer. In respect of Rule 24(7), the panel could consider whether or not there was sufficient evidence to find the facts proved. In terms of Rule 24 (8) the panel could consider whether sufficient evidence had been presented to support a finding of impairment.

The panel were concerned that Registrant B was neither represented nor present and invited the legal assessor to address it on the issue of whether or not there was a case to answer issue in respect of any or all of the charges.

The legal assessor suggested that there was an issue regarding a particular allegation. The panel noted that all three registrants were facing the same allegation:

> *"Failed to ensure that correct procedures and protocols were carried out in relation to controlled drugs at the home."*

The only witness to these identical charges was Witness 2. She told the panel that on 17 June 2017 she was present at the home. You had been suspended from the home for some time. Registrant B and Registrant C had also been suspended. The nurses on duty that day were agency nurses. These nurses raised two complaints with her, stating they were not able to find a controlled drug register. In addition, they could not find boxes for the safe disposal of medication. They dealt with this problem by starting a brand-new controlled drug register and ordering new boxes.

The panel were invited to have regard to the wording of the charge. The use of the word “failed” implied that there was a duty, on the part of the registrant, to do something. The words “to ensure” suggested that this duty was heading towards the absolute.

One of the potential concerns raised by the legal assessor was that the charge could be interpreted as the NMC seeking to hold these registrants responsible for the state of the home at a time when they were prohibited from either being physically present at the home or playing any other part in the running of the home. That being the case, there was a clear argument that they would not be under any duty let alone a duty to ensure.

The further concern was that the allegation was based on hearsay evidence of a complaint by the agency nurses. It is not clear how rigorous the search was for either the drug register, or for the boxes. On the face of the evidence, the panel has no information to test the robustness of the search process that led to the conclusion that two essential items were missing. Did the two nurses carry out a rigorous search or did they start a new book because it was easier?

A decision on this issue did not require the panel to make any finding with regard to the credibility and reliability of the sole witness.

The legal assessor referred the panel to the case of AD v NMC 2014 CSIH 90 where the Scottish Appeal Court was critical of a panel who failed to test the robustness of an investigation process based on the elimination of suspects. Was there any evidence of the investigation conducted by the two nurses who reported to Witness 2 that there was no controlled drugs register and there were no boxes?

A further issue to consider was whether or not the panel were satisfied that a finding of impairment could be made. In order to make a finding of impairment the panel would have to be satisfied that there was misconduct. Could there be a finding of misconduct? Could the panel make a finding that there had been a significant departure from the standards expected of a qualified nurse?

Ms Mohamed invited the panel to consider that there was a case to answer and allow consideration of the charge to continue. She accepted that the sole evidence in relation to this charge was Witness 2. She invited the panel to consider matters on the basis that she would be found to be a credible and reliable witness. It was a matter for the panel to consider whether there had been sufficient evidence presented.

Ms Mohammed referred the panel to the statement of Witness 2 and in particular the observation that Registrant B was accountable for what went on in the home. She should have noted that there was no controlled drug register.

The panel heard and accepted the advice of the legal assessor. In respect of issues regarding facts to find the charges proved he referred the panel to the case of R v Galbraith [1981] 1 WLR 1039. If there was no evidence then the charge should be stopped. If there was evidence but it was of a vague or tenuous nature then it also should not be taken to the next stage. In respect of the impairment issue he reminded the panel that it would need to be satisfied that there had been

misconduct. If the facts were found proved, would the panel be satisfied that there had been a significant departure from the standards expected of a registered nurse?

Shortly after it retired to consider the issue of Charge 9, it decided that it should also hear submissions from the parties in relation to Charge 10:

> *"Failed to ensure that the Deprivation of Liberty Safeguards ('DoLS) procedure was followed in relation to one or more residents".*

At the reconvened hearing the panel informed the participants, through the legal assessor, that they wished to be addressed on the issue of whether sufficient evidence had been presented in support of this charge.

The legal assessor indicated that the evidence that supported this charge was the witness statement of Witness 3. In her witness statement she talked about a visit on 2 June 2017 and raising a number of concerns in a report. The issue was whether or not the NMC had provided sufficient evidence that DoLS procedure was required.

Ms Mohamed invited the panel to consider that there was sufficient evidence. Having regard to the wording of the charge that the NMC required to do was to satisfy the panel that at least one patient required a DoLS to be assessed. She invited the panel to have regard to the documentary evidence.

You and Registrant C indicated that they adopted the issues raised by the panel.

You invited the panel to have regard, in addition to the matters raised by the panel, Charges 6, 7 and 8. He submitted that the witnesses failed to understand the dietary needs of the residents as they did not know them. He also submitted that Individual

A was responsible for events as she entered the kitchen when she ought not to have done so.

The panel heard and accepted the advice of the legal assessor and took account of the submissions made.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

Charge 6

The panel considered the no case to answer application put forward by you and your submissions. It also had regard to the witness statements of Witness 3, Witness 6 and Individual A.

The panel noted that this charge was in relation to six separate residents which as a result of alleged failures surrounding dietary requirements resulted in weight loss, the need for supplements and residents being fed food they disliked or that was against their religious or personal beliefs.

The panel considered the evidence in relation to Resident A, that although the patient was supposed to be on a Halal diet, that he was only ever given pasta and milk. The panel referred to the statement of Witness 3 which states:

> *"It was noted that Patient A's care plan stated that he was to receive a Halal diet. Individual A told me that Patient A previously told her that he is only ever*

fed pasta and never given a choice of meals. On speaking with Patient A, he told me that he did require a Halal diet due to being a Muslim and that he was only ever fed pasta even though this is not what he wanted.

Following my conversation with Patient A, I went to speak with the cook to enquire about Patient A's dietary needs. However, the cook told me that she was not aware of any residents with dietary requirements other than Patient F. Therefore, I was concerned as the cooks response seemed to confirm that Patient A was not being fed a diet which was appropriate for his religious belief. Feeding a patient a diet which is contrary to his cultural and religious beliefs is completely unethical.

I was also concerned by the cook's comment as I am aware the Patient A is not the only other resident with special dietary requirements".

She also stated:

"The Registrant as registered manager of Cheam Cottage has the overarching responsibility to ensure that equality and diversity standards are met, and this would include observing and providing for the residents special dietary requirements in the case of vegetarians and persons requiring a Halal diet. He is also responsible to ensure those with low BMI and those who have difficulty chewing and swallowing are being provided a diet suitable to addressing their needs".

The panel considered evidence relating to Resident E and the letter from the dietician dated 31 March 2017 which details dietary recommendations for the patient. The panel referred to the statement of Witness 6 that states the recommendations were not followed and were not documented in the patient's care plan.

The panel also had regard to the evidence relating to Patient F and Witness 3's statement that describes a *'confusion amongst staff members'* around this patient's dietary requirements. It also considered submissions from you that you had been informed by Resident F's friend that the Resident F *'was not really a vegetarian'* and was therefore feeding Resident F a diet that included fish.

The panel also noted the evidence that main meals were being mixed together in the same dish as desserts and were presented to the residents to consume.

The panel considered that there is clear and sufficient evidence to support this charge at this stage. As the Home's manager, you had the overarching duty to ensure all the residents were fed a diet that complied with their needs, beliefs and preferences. You also had a duty of care, where a patient no longer has the mental capacity, to ensure their dignity is maintained by following their specified dietary requirements and to ensure that all patient records were accurate to ensure no confusion.

There are concerns of this nature in relation to six residents, which are wide ranging and over a significant period of time, and the panel concluded there is sufficient evidence of repeated failures within the home. The panel therefore find there is case to answer in relation to this charge. You challenged the factual basis for the charges in cross examination. You suggested that there were cogent reasons for the residents receiving the food that they did. This dispute could not be resolved at the stage of no case to answer. It is open for you to lead evidence and make submissions, on whether or not the facts are proved at a later stage of the case.

Charge 7 and Charge 8

The panel had regard to the statement of Individual A and Witness 2 when considering this application for these two charges. It noted there was sufficient evidence the events occurred and that it was witnessed by the residents. It noted the events were not disputed by you although the reasons for the events taking place is contested.

The panel considered that confrontation of any kind should not happen in front of residents, especially vulnerable residents with a cognitive impairment.

The panel therefore concluded that there was sufficient evidence to support these charges at this stage. The panel therefore find there is a case to answer in relation to these charges. It is open for you to lead evidence setting out the context in which these events took place and challenging the view taken by the NMC witnesses.

Charge 9

The panel again considered the evidence put forward by the NMC. The panel noted the timeline of events and that on 17 June 2017 you along with Registrant C and Registrant B were suspended from their posts, pending an investigation and were not permitted to be on site. The panel considered that as this was a Home regularly inspected and visited, there would have been correct procedures and protocols in place and that there is no evidence that this was non-existent prior to this.

The NMC's evidence was that two nurses, who were new to the home, could not find the controlled drugs register nor could they find disposal boxes. There was no evidence provided with regard to where either the register or boxes were stored.

The panel was of the view that there must have been a record somewhere on site as there is evidence of there being controlled drugs at the Home. The panel considered

that there is no evidence which details the procedures were not being followed. It also acknowledged no mention of how rigorous the search was for the missing items. With all of the home's nursing staff suspended the new nurses opened a new register and ordered new boxes. Without the live evidence of either of these nurses the panel could not assess how robust the search was to find either the drugs register or the disposal boxes.

The panel therefore concluded that there was not sufficient evidence before it to support this charge. The panel therefore found there was no case to answer in relation to charge 9.

Charge 10

The panel considered the evidence put forward by the NMC. In particular the evidence of Individual A, who referred to the DoLS procedure twice in her witness statement. The panel noted the only evidence relied upon by the NMC in support of this charge is her CCG Report of 2 June 2016.

In her CCG Report dated 2 June 2016, Individual A only mentioned DoLS with regard to Residents B and L. She stated that Resident B had a DoLS in place from March 2017, but there was no further evidence relating to DoLS in respect of this patient. She stated that Resident B became a resident at the Home in 2016, but there is no evidence that a DoLS was required at that point.

Individual A also refers to Resident L, who she stated in the same report:
'…appeared comfortable, was sat down and was neither confused or disorientated.'
The panel considered that was no evidence to indicate that a DoLS would be required.

The panel considered this evidence and concluded that it was limited and tenuous in nature. The panel noted there is no evidence before it that stated, in terms, that the residents who required a DoLS did not have one and that, if one was in place, the correct procedures were not being followed. The panel also noted that there was no other compelling documentary evidence detailing the DoLS issues.

The panel concluded that as there was not sufficient evidence before it to support this charge there was no case to answer in respect of Charge 10.

Background

This case involves the allegations of a substandard level of care provided to residents at Cheam Cottage (the Home) which was a nursing home at the time of the allegations.

The Home provided care to elderly residents with mental and physical health problems, mainly arising from their diagnosis of advanced and complex dementia. All residents were fully funded by public funds.

You were the registered manager of the Home and a registered nurse. As registered manager, you had overall responsibility to oversee that adequate care was provided to residents of the nursing home. This included the responsibility to provide that all necessary assessments were carried out, as well as all necessary nursing documentation was completed in the appropriate file and to maintain that correct and consistent nursing care was given to residents.

The NMC regulatory concerns with your practice are that you failed to safely and effectively manage a nursing home in that you failed to:

- Ensure an adequate standard of record keeping.
- Document wounds, bruises and dietary need appropriately or at all and/or ensure that the Homes staff did.

- Prevent pre-written notes that fabricated residents' daily care.
- Make necessary and timely referrals to appropriate specialists.
- Give appropriate regard to residents' changing dietary needs.
- Manage appropriate behaviour by Home staff.

The NMC regulatory concerns regarding Registrant C are as follows:

- Poor documentation.
- Failure to document wounds, bruises and dietary needs appropriately or at all.
- Prewritten notes that fabricated residents' daily care and possible associated dishonesty.
- Failures to make necessary and timely referrals to appropriate specialists.
- Failure to give appropriate regard to residents' changing health and needs.
- Falling asleep whilst on duty.

The NMC regulatory concerns regarding Registrant B are as follows:

- Poor documentation.
- Failure to document wounds, bruises and dietary needs appropriately or at all.
- Failure to make necessary referrals to appropriate specialists.
- Failure to give appropriate regard to residents' changing health and needs.

On 16 February 2017 a safeguarding alert was raised by Epsom and St Helier Trust when a resident from the Home was admitted to hospital with multiple severe pressure sores.

A further safeguarding alert was raised on 3 April 2017 in relation to another resident. On 10 May 2017, a safeguarding meeting was held at the London Borough of Sutton (LBS) and the decision was made to conduct an inspection of the Home. At

the same time, the Home was stopped from accepting any new residents. It was decided that the care home support team with Individual A would need to visit the Home and check all residents physically and their care plans and records to ensure that they were receiving safe care. Witness 5, who is the Assistant Director for Quality Nursing People, and Head of Continuing Care at NHS Sutton Clinical Commissioning Group (CCG) provided an overview as to the steps that were taken in term of inspections and safeguarding meetings with the Home.

Individual A was a Nurse Assessor for Continuing Care at Sutton CCG. Cheam Cottage was her allocated nursing home within Continuing Care. She regularly attended the Home to carry out inspections on residents within the Home.

Individual A visited the Home on 9 May 2017 as part of her routine visits. During this visit she had concerns regarding Patients A, B, C, D and F.

On 2 June 2017 and 8 June 2017, Individual A visited the Home as part of an inspection. During these visits she had concerns with the care of Patients A, B, C, E, F and G. Social worker Witness 3, who attended the inspection along with Individual A, had concerns in relation to the care of Patients A, B and F.

Witness 4 who is a registered nurse and a clinical nurse lead for discharge, was also present for the inspection at the Home on 8 June 2017. She had previously visited the Home on 30 May 2017 where she had various concerns about the Home.

A meeting took place on 9 June 2017 between members of the LBS and you and your wife where a number of concerns were raised.

Due to these concerns, you were asked to step down from management on 9 June 2017 and your wife, a carer in the Home, was asked to take over management in your absence.

Following the meeting on 9 June 2027, Sutton CCG took the decision to remove the residents which were fully funded by NHS Continuing Healthcare and LBS informed all other Local Authorities regarding the concerns and requested reviews of the residents under the Safeguarding Vulnerable Adults (SVA) process.

Individual A visited the Home on 13 June 2017 for a final time. She had concerns regarding Patient H.

In 16 June 2017, your wife was also requested to remove the employed registered nurses from the rota and the shifts would be covered by agency staff. The agency staff took over on 17 June 2017.

As a result of the concerns raised, a nurse consultant, Witness 2, attended the home to assist them in becoming compliant with care standards and documentation standards.

Witness 2 attended the Home on three occasions, 15 June 2017, 16 June 2017 and 17 June 2017.

On 19 June 2017, an action plan was received from the CQC following an inspection on 30 May 2017. There were a number of concerns detailed in Witness 2's statement. She discussed the concerns with your wife who was now managing the Home. However, your wife decided to voluntarily close the Home.

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

- Individual A: Nurse Assessor for Continuing Care, Sutton CCG;
- Witness 2: Nursing Consultant;
- Witness 3: Social Worker at the London Borough of Sutton (LBS);
- Witness 4: Care Home Support Clinical Lead;
- Witness 5: Head of Continuing Care at NHS Sutton Clinical Commissioning Group (CCG);
- Witness 6: Lead Nurse for the Vanguard Program;
- Witness 7: Handwriting expert.

The panel also heard oral evidence from you and Registrant C.

Decision and reasons on facts

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

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

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

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

Charge 1a

That you, a Registered Nurse at Cheam Cottage ('the Home'):

1) *Failed to maintain / ensure an adequate standard of record – keeping / documentation was maintained in the Home:*

   a) *As set out in Schedule A;*

Schedule A 1

Failed to ensure that controlled drug checks were undertaken / recorded

No case to answer

Charge A 2

The nutritional assessment of zero was incorrect as the resident was able to chew and swallow, albeit with difficulty

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Individual A and Registrant C.

Individual A stated in her evidence that *"The care plan on Patient A 's file notes that Patient A had sores in his mouth and required a mashed food diet. However, this is not consistent with his nutritional assessment in which he scores zero for chewing and swallowing due to having no teeth. In addition, I found this assessment to be incorrect as Patient A could chew and swallow albeit with difficulty".*

The panel was not provided with any other evidence that there was a score of zero on this patient's nutritional assessment. Registrant C, in her evidence, asked to be shown the assessment and it could not be provided. The panel determined that there was insufficient evidence to conclude that you failed to provide an adequate standard of documentation. It therefore found charge 1a in respect of Schedule A 2 not proved.

Charge A 3

No adequate record of the resident's need for a halal diet

This charge is found not proved.

In reaching this decision, the panel took into account your evidence and the evidence of Individual A.

Individual A stated in her evidence that *"During my conversation with him, Patient A told me that he needed to be on a halal diet. Whilst this was noted on one page of the care plan, not all documentation in the file was conducive to him receiving a halal diet".*

The panel took into account that Patient A's need for a halal diet was recorded on one document. The panel determined that the NMC have not provided sufficient evidence of a failure in respect of the documentation surrounding the resident's need for a halal diet. The panel therefore found charge 1a in respect of Schedule A 3 not proved.

Charge A 4

One, or more, documents in the residents file were blank / not completed

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 3.

Witness 3 stated in her evidence *"I noted that a number of documents which were in the file remained blank. These were the 'thinking ahead' form; the likes and dislikes form; the key information sheet; and the signature sheet which contains details of nurses responsible for the patient's care."*

The panel was not provided with a specific document which had been left blank in relation to this charge. The panel determined that the NMC have not provided sufficient evidence of a failure in respect of incomplete or blank documents. The panel therefore found charge 1a in respect of Schedule A 4 not proved.

Charge A 5

Person-centered / well- being documents were unsigned / undated

This charge is found not proved.

In reaching this decision, the panel took into account Registrant C's evidence and the evidence of Witness 3 and your evidence.

Witness 3 stated in evidence *"In addition to this, documents were unsigned and undated and by this I refer to all the documents located in the person centred health and wellbeing section of the patient's file."*

The panel heard from Registrant C that she was in the process of reviewing and changing all these documents because the care plans had changed format. Her evidence was that she had not finished this process and some had been left unsigned.

You confirmed to the panel that you had given Registrant C the task of reviewing and changing all the care plans in the Home to the new format.

The panel found this explanation to be a plausible and acceptable reason as to why documentation was unsigned and undated and did not amount to failure on your part. The panel therefore found charge 1a in respect of Schedule A 5 not proved.

Charge A 6

> *On 9 May 2017, the residents repositioning chart had not been updated since 6 am that morning*

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Individual A.

Individual A stated in her evidence *"The repositioning chart had not been updated since 6am that morning, and it was now 3pm. Therefore it was not possible for us to tell how often the Patient was repositioned".*

You acknowledged in your evidence that the repositioning chart had not been updated and it was a 'very busy at the time'.

The panel determined that as registered manager, you had the responsibility to oversee that all documentation was completed in a timely manner by the staff at the Home and you did not do so. The panel therefore found charge 1a in respect of Schedule A 6 proved.

Charge A 7

On 9 May 2017, the residents food chart had not been completed since lunch in respect of the residents fluid intake / as necessary

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Individual A.

Individual A stated in her evidence *"The food chart had not been completed since lunch to include fluid intake. I also noted that there was no water juice available to Patient C as the jug of juice was across the room with the cup turned upside down".*

You accepted in your evidence that this resident's food chart may not have been completed in a timely manner.

The panel determined that as registered manager, you had the responsibility to arrange that staff had sufficient time to complete necessary documentation in order to maintain standards in the Home. The panel therefore found charge 1a in respect of Schedule A 7 proved.

Schedule A 8

On 9 May 2017,the residents hourly observation chart had not been completed since 11am

This charge is found not proved.

In reaching this decision, the panel took into account your evidence and Registrant C's evidence.

Registrant C told the panel that there was no 'hourly observation chart' at the Home.

You stated that the council did not pay enough to look after the residents and hence there was insufficient time to complete documentation.

The panel determined that as the NMC have not provided the document titled *'hourly observation chart'* or any other information about the document, it was unable to provide evidence of a failure. The panel therefore found charge 1a in respect of Schedule A 8 not proved.

Schedule A 9

> *The geriatric depression formulation was inaccurate and / or clinically inappropriate*

This charge is found proved.

In reaching this decision, the panel took into account your evidence, Individual A's evidence and the documentary evidence.

Individual A stated in her evidence *"I noted that Patient C had a depression scale in place, but that the incorrect clinical assessment was carried out being the geriatric assessment. As noted above, the geriatric assessment is for patients who are cognitively intact. Patient C was not verbally or non-verbally responsive and there was no way that a geriatric depression assessment could have been carried out".*

Your evidence was that you were unaware that this was an incorrect assessment form.

The panel accepted Individual A's evidence that the patient was non-verbal. The panel had sight of the appropriate assessment which you should have provided to staff to complete for non-verbal residents. The panel determined that as registered manager, you had the responsibility to audit and arrange that staff had accurate and appropriate forms to fill out in order to maintain proper standards of documentation in the Home. The panel therefore found charge 1a in respect of Schedule A 9 proved.

Schedule A 10

> *No record in the care plan / daily notes relating to abnormal findings in relation to the residents body temperature between January 2016 and May 2017*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and Registrant C.

Witness 6 stated in her evidence *"From January 2016 to May 2017 Patient C was consistently recorded to have a body temperature of 34 or 35 ºC, and to have a respiratory rate of 24 between January 2017 and May 2017. These are abnormal findings, yet there is nothing in the care plans or daily care notes to suggest that these findings were being addressed by the staff at Cheam Cottage".*

However, the panel had sight of Patient C's monthly vital signs records exhibited by Witness 6 and noted that Registrant C had recorded an abnormal finding between

the dates in issue and accepted Registrant C's evidence that there was no reason to duplicate this documentation elsewhere. The panel saw no evidence of a failure. The panel therefore found charge 1a in respect of Schedule A 10 not proved.

Schedule 11

No record in the care plan / daily notes relating to abnormal findings in the residents respiratory rate between January 2017 and May 2017

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence *"From January 2016 to May 2017 Patient C was consistently recorded to have a body temperature of 34 or 35 ºC, and to have a respiratory rate of 24 between January 2017 and May 2017. These are abnormal findings, yet there is nothing in the care plans or daily care notes to suggest that these findings were being addressed by the staff at Cheam Cottage".*

The panel had sight of the abnormal readings as recorded by you. You advised that all readings were reported to Registrant D who would take any necessary action. You accepted that you could have also recorded the readings in the daily notes but there was no reason do to so. The panel accepted your explanation. The panel therefore found charge 1a in respect of Schedule A 11 not proved.

Schedule A 12

The daily care notes lacked detail / failed to address the residents condition / changing needs

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's evidence.

Witness 6 stated in her evidence *"I found that all daily care notes were lacking in detail on the observations and condition of the patient, and they were in no way sufficient to paint the picture for 12 hours of care given to the Patient in any given day. The care notes were vague, and each entry was very similar to the one before it. The notes did not address the Patient's conditions or care needs".*

The panel had sight of the daily care notes and found them to be representative of Registrant C's shift only.

The panel accepted that Registrant C's entries into the care notes would not have been sufficient to paint the picture for 12 hours of care given to the Patient. However, the panel determined that she would only have been present at the Home for a part of the time and she documented what she did witness during her 4 hour shift. The panel accepted that there was a failure on behalf of the afternoon shift nurses to document what happened after Registrant C finished her shift.

The panel accepted Individual A's evidence and was of the view that as registered manager, you had the responsibility to ensure that the afternoon shift nurses completed their documentation and you failed to do so. The panel therefore found charge 1a in respect of Schedule A 12 proved.

Schedule A 13

The notes were inconsistent with the residents development of bed sores

This charge is found not proved.

In reaching this decision, the panel took into account Witness 6's evidence.

Witness 6 stated *"I was concerned as to whether the notes were an accurate record of the care given to the Patient as the notes state consistently that the Patient had been turned regularly, but this is not consistent with the development of pressure sores".*

The panel also had sight of Patients C's notes.

The panel considered that there could be other explanations for the development of pressure sores for this resident. The panel was of the view that Registrant C had made notes about the patient's care and there was no other evidence to suggest that anything significant was missed or lacking in detail during the shift that was not documented. The panel determined that the NMC had not provided sufficient evidence to persuade it that the records were inconsistent. The panel therefore found charge 1a in relation to Schedule A 13 not proved.

Schedule A 14

The Care Plan did not provide sufficient detail relating to the type and use of the pressure relieving mattress

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence *"This care plan, which was signed [Registrant C], is not comprehensive and does not provide sufficient information. I would have expected the care plan to contain detail as to whether the pressure relieving mattress and cushion was air or foam, what level the pressure relieving mattress and cushion needed to be set at and how often these needed to be checked. Therefore, I was concerned that while this document was completed, [Registrant C] failed to complete it to an acceptable standard".*

The panel also had sight of the pressure sore care plan signed by Registrant C.

The panel considered that the Tissue Viability Nurse (TVN) would be the one to give more information regarding a specific type mattress. The panel accepted that this would have been provided directly to you. However, the panel so no evidence of this. The panel therefore found charge 1 in relation to Schedule A 14 not proved.

Schedule A 15

The Care Plan did not accurately reflect the concerns of the TVN

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence *"The evaluations document that Patient C was regularly repositioned, that cream was applied to pressure areas and that skin was intact. However, this is in direct conflict with the TVN's findings which identified several areas of concern and pressure sores were located on the Patient's body. As*

noted above, the TVN also identified concerns as to whether the Patient was in fact being regularly repositioned".

The panel noted that the TVN came on 20 June 2017. You had been suspended from the Home since 9 June 2017. You would not have been responsible for this residents care plan at the time because you were not working at the Home. The panel therefore found charge 1a in relation to Schedule A 15 not proved**.**

Schedule A 16

The Nutritional Care Plan dated 18 May 2016 did not contain reference to the dieticians recommendations / contained confusing information

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence *"there was a nutrition care plan in place dated 18 May 2016; however this did not reference the dietitian recommendations and overall contained vague, insufficient and contradictory information. This care plan was clearly signed by [Registrant C]"*

The panel noted that the NMC had not produced any documents to show what the dietician's recommendations were, it only had sight of the care plan.

The panel determined that the NMC had not provided evidence of the recommendations and therefore there was no evidence of a failure to provide reference to those recommendations. The panel therefore found charge 1a in relation to Schedule A 16 not proved.

Schedule A 17

No reference to the residents decreasing BMI / weight loss and / or nursing interventions to address such matters

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6

Witness 6's evidence states *"There is no reference to the Patient's consistently decreasing BMI and weight loss, and no nursing interventions to prevent these conditions from deteriorating further. Therefore, there is a concern that [Registrant C] did not complete a comprehensive care plan which was of an acceptable standard".*

The panel had sight of Patient C's nutrition care plan and determined that there was no evidence of decreasing BMI or weight loss so there was no need for Registrant C to refer to this in the care plan. The panel determined that the NMC had provided evidence of a failure. The panel therefore found charge 1a in relation to Schedule A 17 not proved.

Schedule A 18

Monthly dependency assessments carried out between January to May 2017 were not signed / dated and / or did not accurately reflect to residents needs

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence *"Between January 2017 and May 2017 there were monthly dependency assessments carried out. These assessments consistently suggested that the Patient had no pressure sores, that the Patient's feet were clean and well cared for and that the Patient required a normal diet. These assessments were not signed or dated, but are in direct conflict with other documentation, and therefore suggest that they were not personalised to the Patient and did not accurately reflect his needs".*

The panel had sight of the patient's dependency assessment. The panel considered that there are dates on the form although it recognised that the form was poorly designed and did not allow for a signature or initial. The panel determined that as registered manager, you had the responsibility to supply staff with accurate and appropriate forms to fill out in order to maintain proper standards of documentation in the Home. The panel therefore found charge 1a in relation to Schedule A 18 proved.

Schedule A 19

> *No record in the care plan / daily notes relating to abnormal findings in relation to the residents body temperature / respiratory rate between January 2017 and May 2017*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence *"From January 2016 to May 2017 Patient C was consistently recorded to have a body temperature of 34 or 35 ºC, and to have a*

respiratory rate of 24 between January 2017 and May 2017. These are abnormal findings, yet there is nothing in the care plans or daily care notes to suggest that these findings were being addressed by the staff at Cheam Cottage".

However, the panel had sight of Patient C's monthly vital signs records exhibited by Witness 6 and noted that Registrant C did record an abnormal finding between the dates in issue, and hence there was no failure. The panel therefore found charge 1a in respect of Schedule A 19 not proved.

Schedule A 20

The residents leg bag did not record when it had been set up

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Individual A.

Individual A's evidence is *"There was no leg bag in place and the catheter bag from the previous bag was still attached. I questioned staff on this and they told me that the bag was changed weekly as it had a port allowing it to empty. While this seemed like an acceptable explanation, there was no date on the bag indicating when it had been set up. Therefore, I am unsure whether the bag had been there for more than a week. The bag should be dated to make clear the date that it requires changing to avoid confusion or missed changes".*

The panel accepted Individual A's evidence. It determined that as registered manager, you had the responsibility to audit and maintain an adequate standard of record-keeping in the Home and you failed to do so. The panel therefore found charge 1a in relation to Schedule A 20 proved.

Schedule A 21

The residents conditions / care needs were not accurately reflected in the notes

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence.

Witness 6 stated in her evidence *"The documentation that was completed was often incomplete and did not contain sufficiently specific information as the information was often vague and generic, suggesting that the documentation was not personalised to the Patient".*

Witness 6 also stated *"[Mr Dudhee], as registered manager of Cheam Cottage, had the responsibility for overseeing the practice run within his care home, to include the practice of his staff. This includes that his staff are providing the standard of care to patients as expected in the NMC code of conduct".*

Your evidence was that you may not have been aware of discrepancies in the records and you delegated the responsibility of record keeping to the registered nurses.

The panel did not have sight of any record signed by you where it could determine that the resident's conditions or care needs had not been accurately reflected. However, it determined that as registered manager, you had the responsibility to oversee that an adequate standard of record-keeping was maintained in the Home and you failed to do so. The panel therefore found charge 1a in relation to Schedule A 21 proved.

Schedule A 22

At a review / inspection on 2 June 2017, the resident was recorded as both being at a high risk of falls and also at no risk at all

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 3 and your evidence.

Witness 3 said in her evidence *"There were two documents relating to the patient's risk of falls and one stated that he was at high risk of falling, and the other stated that there was no risk of falling".*

Your evidence was that there could have been a slight mistake by the person documenting.

The panel was not provided with any other evidence other than Witness 3's witness statement. It did not have sight of the two documents referred to by Witness 3. The panel determined that the evidence was insufficient to determine that you had failed to ensure an adequate standard of record keeping or documentation. The panel therefore found charge 1a in relation to Schedule A 22 not proved.

Schedule A 23

The nutritional screening assessment scored as '0' reflecting that the resident had no issues, whereas the resident was also recorded in the 'care and well-being section' as being thin, with a poor appetite

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 3 and your evidence.

Your evidence was that you delegated this responsibility to the registered nurses

The panel took into account that the only reference to a score of '0' is in Witness 3's report.

The panel determined that there was no clear evidence to support his charge. The panel therefore found charge 1a in relation to Schedule A 23 not proved.

(Schedule A 24 omitted from the charge)

Schedule A 25

Staff amended the personal care assessment by adding an additional section stating that the patient had had no falls as well as recording conflicting evidence that the resident was at a higher risk of falling

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Individual A and Witness 7 and your evidence.

Individual A's evidence was *"My first observation was that Patient G had a personal care assessment in his folder. This assessment is a pre-formulated assessment which should not be altered or amended by staff. The assessment is for the purpose of scoring the level of support the Patient requires. I noted that the nursing staff had added a section on the bottom of the assessment. This indicated that the Patient had no falls, which placed him at a higher risk of falling and therefore he was scored a 5 for risk of falling".*

The panel had sight of the patient's personal care assessment and noted where an amendment had been made to the form. The panel also noted that Registrant C accepted in her oral evidence that she made this amendment to the form. The panel determined that as registered manager, you had the responsibility to audit and maintain adequate standard of record keeping by staff in the Home. The panel therefore found charge 1a in respect of Schedule A 25 proved.

Schedule A 26

> *No care plans / risk assessments / management plans were in place in relation to the residents diabetes*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Individual A, Registrant C and your evidence.

Individual A's evidence stated *"There were no care plans or risk assessments in regard to his diabetes which raises a patient safety concern. I would have expected that the Patient file would contain a clear management plan for the long term condition".*

You accepted in your oral evidence that this should have been documented in the care plan. However, you confirmed the evidence of Registrant C when she stated that all the care plans were being changed by her to the new format and this one had not yet been completed.

The panel had sight of the patient's records and noted that they did not detail a clear management plan for their diabetes.

The panel accepted Registrant C's explanation and this was confirmed by you in your evidence. The panel therefore found charge 1a in relation to Schedule A 26 not proved.

Schedule 27

> *The geriatric depression scale formulation on 18 May 2017 was inaccurate due to the resident being cognitively impaired and / or clinically inappropriate*

This charge is found proved.

In reaching this decision, the panel took into account yours, Registrant C's and Individual A's evidence.

Individual A stated in her evidence *"I noted from the Patient's file Patient G was cognitively impaired. A geriatric depression scale was formulated on 18 May 2017.*

However, my concern is that the geriatric depression scale is intended for patients who are cognitively intact. Patient G's cognitive state is such that he would not have been able to answer the questions on the geriatric scale, and therefore the test result would have been completely inaccurate due to the assessment being clinically inappropriate".

The panel also had sight of the residents geriatric depression formulation completed by Registrant C. Registrant C informed the panel in her evidence that this was the only available form within the Home.

Your evidence you stated that Individual A should have provided you with the appropriate assessment forms.

The panel accepted Individual A's evidence that due to the patient's cognitive state Registrant C would not have been able to ask the patient questions on the geriatric scale and get answers and so determined that the test result was inaccurate due to the assessment being clinically inappropriate.
The panel determined that as registered manager, you had the responsibility to supply staff with accurate and appropriate forms to fill out in and to audit and maintain an adequate and accurate standard of documentation in the Home. The panel therefore found charge 1a in respect of Schedule A 27 proved.

Schedule A 28

> *No care records completed / on file prior to 2016, despite the resident having moved into the accommodation in 2010*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence that *“On review of the file, my first observation was that there were no care records on the file prior to September 2016, and there was no daily care record in the file prior to 24 May 2017. This was concerning as Patient H was moved into the Home sometime in 2010, being around six years before any care documentation appears on the file. I cannot say with certainty whether this was because I was given documents from a specific time frame to review, or if there was a complete failure of Cheam Cottage to document this Patient's care prior to 2016. However, the latter would be unacceptable. Care documentation should have been filled out immediately on Patient H being moved into Cheam Cottage.”*

The panel took into account that it was unclear whether Witness 6 had been given all of the documentation to review or just the documentation from a particular time frame. The panel determined that there was no evidence for it to conclude that there were no care records prior to 2016 for this resident. The panel therefore found charge 1a in relation to Schedule A 28 not proved.

Schedule A 29

> *No daily care records completed / on file prior to 24 May 2017, despite the resident having moved into the accommodation in 2010*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence that *“On review of the file, my first observation was that there were no care records on the file prior to September 2016, and there was no daily care record in the file prior to 24 May 2017. This was concerning as Patient H was moved into the Home sometime in 2010, being around six years before any*

care documentation appears on the file. I cannot say with certainty whether this was because I was given documents from a specific time frame to review, or if there was a complete failure of Cheam Cottage to document this Patient's care prior to 2016. However, the latter would be unacceptable. Care documentation should have been filled out immediately on Patient H being moved into Cheam Cottage."

The panel took into account that it was unclear whether Witness 6 had been given all of the documentation to review or just the documentation from a particular time frame. The panel determined that there was no evidence for it to conclude that there were no care records prior to 24 May 2017. The panel therefore found charge 1a in relation to Schedule A 29 not proved.

Schedule A 30

> *In June 2017, no explanation for an increase of a previous aggregate Waterlow pressure score of 14 / record of composite scores from 14 to 22*

This charge is found not proved.

In reaching this decision, the panel took into account Witness 6's evidence and Registrant C's evidence.

Witness 6 stated in her evidence *"I also noted that a waterlow pressure ulcer skin assessment was carried out on a monthly basis between September 2016 and May 2017 with an aggregate score of 14 throughout these assessments. I am unable to comment on whether these assessments were accurate, but it seems unlikely that the score would remain exactly the same especially in the instance where Patient developed significant pressure sores. I noted that the majority of these assessments were signed by initials that appeared to be 'AL' or 'AC' but I am unable to say with certainty what the initials were".*

The also heard evidence from Registrant C that she would circle parts of the form and it is possible that these circles are not visible on the photocopied versions available to the panel. The panel requested that the NMC provide the original copy of the form to verify Registrant C's explanation. However, the NMC was unable to produce originals.

The panel accepted Registrant C's explanation for what might have happened with the documentation. The panel determined that the evidence produced by the NMC was insufficient to conclude that there was a failure. The panel therefore found charge 1a in relation to Schedule A 30 not proved.

Schedule A 31

> *The Dependency Level Assessment Tool undertaken between January and May 2017 contained conflicting information when compared with the requirements of the residents care plan*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 said in her statement "*There were no signatures on any of the assessments and therefore I am unaware of who completed them. However, these assessments contained conflicting information when compared to the patient's condition and to other documents on the Patient's file".*

The panel determined that the NMC did not draw the panel to any specific conflicting information within the documentation, hence there was no evidence of a failure. The panel therefore found charge 1a in relation to Schedule A 31 not proved.

Schedule A 32

No record of the residents normal / abnormal body temperature or breathing rate

This charge is found not proved.

In reaching this decision, the panel took into account the vital signs documentation. The documentation showed the body temperature and breathing rate for all of the months in issue. The panel determined that the information recorded in the vital signs documentation contradicted the charge. The panel therefore found charge 1 in relation to Schedule A 31 not proved.

Schedule A 33

Between 24 May 2017 and 16 June 2017, the residents notes lacked detail / appeared inconsistent with the appearance of the patient

This charge is found proved.

In reaching this decision, the panel took into account your evidence and Witness 6's evidence.

Witness 6 stated in her evidence *"My concerns as it regards Patient A's daily care notes were that the notes were not comprehensive and did not suffice to account for 12 hours of care provided. For example, on 24 May 2017 the notes stated "in bed*

part of the day, reposition on alternate sides maintained, pressure area care continued".

In your evidence you stated that you delegated this responsibility to the other registered nurses but you accepted that there may have been mistakes in some of the record keeping.

The panel also heard evidence from Registrant C that she only worked 4 hour shifts in the day and so would not have been able to give more detail than what was in the resident's notes about what she witnessed during her shift.

The panel considered that Registrant C's entries into the resident's notes would not have been sufficient to paint the picture for 12 hours of care given to the patient because she was only on shift for 4 hours. The panel accepted there was a failure by the nurses on the afternoon shift to document the care they provided. However, the panel determined that as registered manager, you had the responsibility to oversee that those nurses documented the care that they provided and you did not. The panel therefore found charge 1a in respect of Schedule A 33 proved.

Charge 1b

That you, a Registered Nurse at Cheam Cottage ('the Home'):

Failed to maintain / ensure an adequate standard of record – keeping / documentation was maintained in the Home:

b) Generally;

This charge is found proved.

In reaching this decision, the panel had regard to the wording of the charge. It could only be satisfied that there had been a general failure if a significant number of the charges, in Schedule A was found proved. The panel considered the facts found proved at charge 1a in relation to Schedule A6, A7, A9, A12, A18, A20, A21, A25, A27 and A33. It determined that because of the broad nature of the failures found proved, it was satisfied that you had failed, generally, to ensure an adequate standard of record-keeping and documentation was maintained in the Home. The panel therefore found charge 1b proved.

Charge 2

Failed to document wounds, bruises and dietary needs appropriately or at all in relation to one or more residents and / or ensure that such documentation was undertaken by staff at the Home

a) As set out in Schedule B;

Schedule B 1

As at 15 June 2017, no care plans / wound assessments in place for one, or more, residents

This charge is found not proved.

In reaching this decision, the panel took into account that you had been suspended from your duty as the manager of the Home on 9 June 2017 and would not have been working on 15 July 2017. The panel determined that you were not responsible for the wounds assessment or ensuring that such documentation was undertaken by staff at the Home at that time. The panel therefore found charge 2a in relation to Schedule B 1 not proved.

Schedule B 2

As at 16 June 2017, there were no set menus in place for the residents / any information in the kitchen to ensure consistency in diets for the residents

This charge is found not proved.

In reaching this decision, the panel took into account that you had been suspended from your duty as the manager of the Home on 9 June 2017 and would not have been working on 16 June 2017. The panel determined that you were not responsible for setting menus or ensuring that such documentation was undertaken by staff at the Home at that time. The panel therefore found charge 2a in relation to Schedule B 2 not proved.

Charge B 3

No adequate record / note that the resident should be on a halal diet

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Individual A.

Individual A stated in her evidence that *"During my conversation with him, Patient A told me that he needed to be on a halal diet. Whilst this was noted on one page of the care plan, not all documentation in the file was conducive to him receiving a halal diet".*

The panel took into account that Patient A's need for a halal diet was recorded on one document. The panel determined that it had been adequately recorded that the resident should be on a halal diet. The panel therefore found charge 2a in respect of Schedule B 3 not proved.

Charge B 4

The resident's dislike of certain food

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Individual A.

Individual A stated in her evidence *"While reviewing patient B's file, I noted that there was a piece of documentation which noted the patients likes and dislikes. The patient was noted to like boiled potatoes, sausages, eggs, porridge and English food. He was noted to dislike vegetables, fish and chips. Upon reading this document, I requested to see patient B. The patient was eating lunch at this time. I observed that there were boiled potatoes, sausages and half a plate of vegetables. I was concerned as the patient was given vegetables even though he was noted to dislike them, and this reinforced the dietary concerns noted above that no regard was given to the patient's dietary requirements or preferences..."*

The panel heard evidence from Registrant C that she did fill in the resident's likes and dislikes and the panel saw this document.

The panel accepted Registrant C's account that she had completed the resident's likes and dislikes in the documentation. The panel determined that you had ensured

that the resident's likes and dislikes were documented by staff at the Home. The panel therefore found charge 2a in respect of Schedule B 4 not proved.

Charge B 5

Documentation in relation to only one wound recorded, despite the TVN noting several areas of concern on 19 July 2017

This charge is found not proved.

In reaching this decision, the panel took into account that you had been suspended from your duty as the manager of the Home on 9 June 2017 and would not have been working on 19 July 2017. The panel determined that you were not responsible for documenting this resident's wound care or ensuring that such documentation was undertaken by staff at the Home at that time. The panel therefore found charge 2a in relation to Schedule B 5 not proved.

Charge B 6

No skin integrity checks / risk assessments in the residents file

This charge is found not proved.

In reaching this decision, the panel took into account Witness 6's evidence and your evidence.

Witness 6 stated in her evidence *"On review of the wound assessment documentation, there was an entry in the Patient's wound chart for 12 June 2017 and*

it recorded a "sore skin break" to the sacrum. This was the only wound that had been recorded on the patient's file... I noted that there were no skin integrity checks or risk assessments for Patient C on the Patient's file".

Your evidence was that you had delegated this to the other registered nurses.

The panel had sight of the Patient C's Wound Assessment documentation and considered that although it was not the most comprehensive, it was what had been provided by the Home for staff to fill out. The panel determined that although the assessments were basic, you had ensured that there were skin integrity checks in the resident's file. The panel therefore found charge 2a in relation to Schedule B 6 not proved.

Charge B 7

> *Care plan failed to provide sufficient detail relating to the residents pressure relieving mattress / cushion*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence.

Witness 6 stated in her evidence *"This care plan, which was signed [Registrant C], is not comprehensive and does not provide sufficient information. I would have expected the care plan to contain detail as to whether the pressure relieving mattress and cushion was air or foam, what level the pressure relieving mattress and cushion needed to be set at and how often these needed to be checked. Therefore, I*

was concerned that while this document was completed, [Registrant C] failed to complete it to an acceptable standard".

Your evidence was that you did not receive any recommendations from the Tissue Viability Nurse (TVN).

The panel also had sight of the pressure sore care plan signed by Registrant C.

The panel considered that the TVN would be the one to give more information regarding a specific type of mattress. The panel accepted that this would have been provided directly to you. However, the panel saw no evidence of this. The panel therefore found charge 2a in relation to Schedule B 7 not proved.

Charge B 8

> *No wound care assessment / wound chart / care plan undertaken in relation to a pressure ulcer between 25 April 2017 and 30 May 2017*

This charge is found proved.

In reaching this decision, the panel took into account your evidence and Witness 6's evidence.

Witness 6 stated in her evidence *"On the 27 April 2017 Patient was seen by the tissue viability nurse ('TVN'). The TVN identified a pressure ulcer of size 8cm x 7cm and advised that this should be sprayed with cavilon and that foam dressing should be applied to the wound. The dressing was to be changed twice weekly…*
Following this visit, I would have expected that a wound chart, wound assessment and care plan would have been developed immediately. However, there was no

record of a wound chart or wound assessment on the Patient's file until 30 May 2017, being over a month later".

Your accepted in your evidence that wound care documentation should have been improved in the Home and you accepted that there was no care plan in place.

The panel determined that as registered manager, you had the responsibility to oversee that all wound documentation was undertaken by staff in the Home and you did not do so. The panel therefore found charge 2a in respect of Schedule B 8 proved.

Charge B 9

> *The wound documentation completed on 30 May 2017 was incomplete / inadequate in that it failed to record the size of the wound / type of wound / dressing required*

This charge is found not proved.

In reaching this decision, the panel took into account Individual A's and Witness 6's evidence.

Individual A stated '*However, on review of the wound care assessment documentation, the only documentation available was an incomplete wound care assessment, a wound chart and a care plan. These documents were dated 30 May 2017, being almost a month after the wound was first documented in the notes".*

Witness 6 stated in her evidence *"There was also an unsigned care plan developed on 30 May 2017, however I found that this care plan was incomplete and contained non-specific care instructions such as…"*

The panel had sight of the wound documentation completed on 30 May 2017 by Registrant C. The panel note that this documentation included the size and type of wounds and the dressing required.

The panel was of the view that the evidence available contradicted the charge. The panel therefore found charge 2a in relation to Schedule B 9 not proved.

Charge B 10

> *Wound chart and care plan was not developed within a reasonable time following the TVN's identification of a pressure ulcer in April 2017*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence.

Witness 6 stated in her evidence *"The evaluations document that Patient C was regularly repositioned, that cream was applied to pressure areas and that skin was intact. However, this is in direct conflict with the TVN's findings which identified several areas of concern and pressure sores were located on the Patient's body. As noted above, the TVN also identified concerns as to whether the Patient was in fact being regularly repositioned".*

The panel noted that the TVN visited in April 2017 and the care plan that the panel had sight of was dated 30 May 2017.

Your evidence was that there would have been a care plan in place and that you were not a specialist in wound care.

The panel accepted the evidence of Witness 6. The panel determined that as registered manager, you had the responsibility to oversee that all wound documentation was undertaken by staff in the Home and you failed to do so. The panel therefore found charge 2a in relation to Schedule B 10 proved.

Charge B 11

> *No supporting records as to how the residents Waterlow scores were calculated between January to June 2017*

This charge is found not proved.

In reaching this decision, the panel took into account Witness 6's evidence and Registrant C's evidence.

Witness 6 stated in her evidence *"I also noted that a waterlow pressure ulcer skin assessment was carried out on a monthly basis between September 2016 and May 2017 with an aggregate score of 14 throughout these assessments. I am unable to comment on whether these assessments were accurate, but it seems unlikely that the score would remain exactly the same especially in the instance where Patient developed significant pressure sores. I noted that the majority of these assessments were signed by initials that appeared to be 'AL' or 'AC' but I am unable to say with certainty what the initials were".*

The panel also heard evidence from Registrant C that she circled parts of the form and it is possible that these circles are not visible in the photocopied versions available to the panel. The panel requested that the NMC provide the original copy of the form to verify Registrant C's explanation. However, the NMC was unable to produce originals.

The panel accepted Registrant C's explanation for what might have happened with the documentation. The panel determined that in the absence of any other evidence it could not prove that you had failed to ensure that staff documented supporting records as to how the residents Waterlow scores were calculated between January and June 2017. The panel therefore found charge 2a in relation to Schedule B 11 not proved.

Charge B 12

> *Inadequate documentation / no record of action taken in respect of the residents weight loss*

This charge is found not proved.

In reaching this decision, the panel took into account your evidence and the evidence of Witness 6.

Witness 6 stated in her evidence *"When attempting to compare this scoring with the actions taken in the care notes to address these risks, there was no record of any action taken in the care notes to evidence that the observation of consistent weight loss was being acted upon".*

In evidence you stated that this was incorrect and that the patient had put on weight.

The panel had sight of the dietician's letter and saw no evidence that Patient E had lost weight. The panel considered that documentation was adequate and there was no duty to take action as there was no evidence of consistent weight loss. The panel therefore found charge 2 in relation to Schedule B 12 not proved.

Charge B 13

Care Plan dated 12 January 2017 is too vague and incomplete

This charge is found not proved.

In reaching this decision, the panel took into account Patient E's nutrition care plan.

The panel was of the view that the care plan was completed on 12 January 2017 by Registrant C and found that it contained all the details that she would have been aware of prior to the dietician's visit in March 2017.

The panel was not provided with any other evidence by the NMC to determine that the nutrition care plan for Patient E was vague or incomplete. The panel therefore found charge 2 in relation to Schedule B 13 not proved.

Charge B 14

Records did not contain information regarding the residents meals being fortified / provision of supplements

This charge is found proved.

In reaching this decision, the panel took into account Witness 6's evidence, Registrant C's evidence and your evidence.

Witness 6 said in her evidence *"There was input from the dietitian received on 31 March 2017 and 20 June 2017. This was advice that the Patient's meals should be fortified and that the Patient should be placed on supplements such as nutritional drinks. However, there is no reference to this input within Patient E's care records or evaluations of the care plan dated January 2017".*

The panel heard evidence from Registrant C that she did not know about the recommendations because the Home manager, you did not tell her you had received the letter. The panel also heard from multiple witnesses that you 'micro managed' the Home and the nurses had 'no power', did not run the shifts and were not fully responsible for patient care.

In evidence you stated that the patient started eating and did not require supplements.

The panel had sight of the letter from the dietician dated 31 March 2017 and noted that the information in the letter was not reflected in the care plan.

The panel determined that you failed to document the resident's dietary needs and failed to oversee that such documentation regarding the resident's meals being fortified / provision of supplements was undertaken by staff. The panel therefore found charge 2 in relation to Schedule B 14 proved.

Charge B 15

> *No recent / updated body map / care plan recording bruises and marks on the arm of the resident*

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's evidence, Registrant C's evidence and your evidence.

Witness 3 stated in her evidence *"My final observation and concern was that body maps stated that on arrival, Patient had bruising on her arms. However, there were no actions in the care plans to follow this up. It was also noted that the patient had new bruises to the ones documented on the body map on file., but there was no updated body map accounting for these new bruises and no care plans or notes of actions taken in relation to these".*

The panel also heard Registrant C's evidence that you cannot document all bruises and that bruises 'come and go'. The panel took into account that Registrant C appeared to accept there was a lack of documentation of bruises for this resident.

In evidence you stated that the resident was on Warfarin and that this medication regularly causes bruises. You stated that you consulted the GP and he confirmed this side effect. You said maybe they [the nurses] did not write down the bruises but that Witness 3 should have been satisfied with this explanation.

The panel determined that as registered manager, you had the responsibility to ensure all bruises and marks on the arm of the resident was documented by staff in the Home and you did not do so. The panel therefore found charge 2a in respect of Schedule B 15 proved.

Charge B 16

No adequate record / documentation relating to one, or more, wounds on the residents body

This charge is found not proved.

In reaching this decision, the panel took into account Witness 6, Registrant C's and your evidence.

Witness 6's evidence stated *"There was an assessment on 15 June 2017 which indicated that here were wounds on Patient H's right foot and hip".* She also stated *"I also noted that on the same date, being 15 June 2017, an assessment was carried out on a wound on the Patient's sacrum and a wound on the Patient's left ankle".*

Your evidence was that you delegated the responsibility for the wound care to the other registered nurses.

The panel considered that there was no other evidence that there were any wounds present when Registrant C last checked the resident and before you were suspended from the Home. The panel determined that the documentation relating to the resident's body was adequate. The panel therefore found charge 2a in relation to Schedule B 16 not proved.

Charge B 17

Wound assessment undertaken on 15 June 2017 lacked clarity as to whether the wound was on the residents right hip or foot

This charge is found not proved.

In reaching this decision, the panel took into account that you had been suspended from your duty as the manager of the Home on 9 June 2017 and would not have been working on 15 June 2017. The panel determined that you were not responsible for the wounds assessment or ensuring that such documentation was undertaken by staff at the Home at that time. The panel therefore found charge 2a in relation to Schedule B 1 not proved.

Charge B 18

> *On 15 June 2017 individual assessments were not carried out in relation to sacrum and ankle wounds*

This charge is found not proved.

In reaching this decision, the panel took into account that you had been suspended from your duty as the manager of the Home on 9 June 2017 and would not have been working on 15 June 2017. The panel determined that you were not responsible for the wounds assessment being carried out or ensuring that such documentation was undertaken by staff at the Home at that time. The panel therefore found charge 2a in relation to Schedule B 18 not proved.

Charge B 19

> *As at 20 June 2015 / the time of a visit by the TVN, various wounds had not been documented.*

This charge is found not proved.

The panel considered that there was a typographical error in the charge and it should have been ‘As at 20 June 2017’. In reaching this decision, the panel took into account that you had been suspended from your duty as the manager of the Home on 9 June 2017 and would not have been working on 20 June 2017. The panel determined that you were not responsible for the wounds being documented or for ensuring that such documentation was undertaken by staff at the Home at that time. The panel therefore found charge 2a in relation to Schedule B 19 not proved.

Charge B 20

Care plans for the residents pressure sores were vague and lacked detail / failed to identify nursing intervention on pain

This charge is found not proved.

In reaching this decision, the panel took into account that the care plans named in this charge link directly to the TVN visit named in Schedule B 19 on 20 June 2017. The panel noted that you were suspended from your duties at the home on 9 June 2017 and would not have been working at the time. The panel determined that this failure in documenting in relation to the care plans could not be attributed to you. The panel therefore found charge 2a in relation to Schedule B 20 not proved.

Charge B 21

Lack of daily review of the wounds recorded (including healing)

This charge is found not proved.

In reaching this decision, the panel took into account Witness 6’s evidence.

Witness 6 stated in her evidence *"There was no documentation of daily reviews of the wounds, there was no information regarding signs to indicate that the wound was healing or alternatively deteriorating further and finally there was no documented timeframe for a re-evaluation of the care plan or effectiveness of dressings recommended. The care plans also failed to detail preventative measures which should be taken to prevent further deterioration of Patient A's skin such as repositioning or nutritional requirements to promote healing".*

The panel determined that the NMC had not provided sufficient evidence other than Witness 6's statement that there was a lack of daily review of the wounds recorded. The panel could not determine that you had not failed to record the daily review of wounds or failed to ensure that such documentation was completed by staff at the Home. The panel therefore found charge 2a in relation to Schedule B 21 not proved.

Charge B 22

> *Having scored an aggregate score of 2 for the nutritional assessments undertaken between January and June 2017 suggesting unintentional weight loss, no record of action taken in relation to the weight loss*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence that *"On all of these assessments, there was an aggregate score of two every month which included a score of two for weight loss, meaning that Patient A was having small unintentional weight loss exceeding 0.5 stone in a period of 3 months. This suggests that there was ongoing unintentional*

weight loss but there is no evidence in the records that this weight loss had been acted on. In addition, this nutritional assessment was not the standard Malnutrition Universal Screening Tool ('MUST') and therefore was not in accordance with the National Standard). I noted that these assessments were initialled by what looked to be 'AL'/'AC', 'EB' and 'PK'".

However, the panel noted from the nutritional assessment that between January and June 2017 his weight stabilised and his BMI remained at 15 and it therefore determined that there was no duty to take any further action during the period of time in question. The panel noted that a significant weight loss occurred for this resident prior to these dates, and this is addressed in Schedule B 23 below. The panel therefore found charge 2a in relation to Schedule B 22 not proved.

Charge B 23

> *Care Plan lacked sufficient detail relating to the residents severe weight loss and reduction in BMI*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence.

Witness 6 stated in her evidence *that 'However, in September to December 2016 there was a decline in the Patient's BMI to 19, and following this there was a significant decline to a BMI of 15 in January to May 2017 and these records were signed by what appeared to be 'AL' or possibly 'AC'… A BMI of 15 is very low. A normal BMI ranges between a BMI of 20-25, and where it drops to 18 or below, this requires a referral to the dietitian to be made. However, there was no evidence of this being done. Additionally, where a patient is consistently losing weight and having*

a decreasing BMI, I would expect to see that a care plan is developed in respect of addressing this weight loss".

The panel had sight of the residents BMI scores and identified a weight loss occurred between December and January 2017 and was signed by Registrant C. The panel also has sight of the patient's care plan and noted that Registrant C did not indicate that any action was taken in relation to weight loss and lacked detail which Registrant C signed.

Your evidence was that this resident's wife was present at the time and encouraged him to eat. You stated that his condition was deteriorating and you expected weight loss. You did not give an account as to why this was not reflected in the care plan.

The panel determined that as the registered manager, you had the responsibility to oversee that all documentation was undertaken by staff in the Home and you failed to do so. The panel therefore found charge 2a in relation to Schedule B 23 proved.

Charge B 24

> *Care plan lacked detail of whether additional nutritional supplements were required / the residents meals needed to be enhanced*

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Witness 6.

Witness 6 stated in her evidence *that 'However, in September to December 2016 there was a decline in the Patient's BMI to 19, and following this there was a significant decline to a BMI of 15 in January to May 2017 and these records were*

signed by what appeared to be 'AL' or possibly 'AC'… A BMI of 15 is very low. A normal BMI ranges between a BMI of 20-25, and where it drops to 18 or below, this requires a referral to the dietitian to be made. However, there was no evidence of this being done. Additionally, where a patient is consistently losing weight and having a decreasing BMI, I would expect to see that a care plan is developed in respect of addressing this weight loss".

Your evidence was that the care plan might have lacked detail, but the main issue is the welfare of the patient.

The panel had sight of the residents BMI scores and identified a weight loss occurred between December and January 2017 and was signed by Registrant C. The panel also has sight of the patient's care plan and noted that Registrant C did not indicate that any action was taken in relation to weight loss and lacked detail.

The panel determined that as the registered manager, you had the responsibility to oversee that all documentation was undertaken by staff in the Home and you failed to do so. The panel therefore found charge 2a in relation to Schedule B 24 proved.

Charge 2b

> *Failed to document wounds, bruises and dietary needs appropriately or at all in relation to one or more residents and / or ensure that such documentation was undertaken by staff at the Home*
>
> *b) Generally;*

This charge is found proved.

In reaching this decision, the panel had regard to the wording of the charge. It could only be satisfied that there had been a general failure if a significant number of the

charges, in Schedule B was found proved. In reaching this decision, the panel considered the facts found proved at charge 2a in relation to Schedule B 8, B 10, B 14, B 15, B 23 and B 24. It determined that because of the broad nature of the failures found proved, it was satisfied that you failed, generally, to document wounds, bruises and dietary needs appropriately or at all in relation to one or more residents and/or ensure that such documentation was undertaken by staff at the Home. The panel therefore found charge 2b proved.

Charge 3a in relation to Schedule C 1-6

Failed to prevent members of staff prewriting / inaccurately recording notes / records;

a) In relation to one, or more, residents as set out in Schedule C;

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Registrant C and your evidence. The panel considered that you had failed to ensure that the nurses working in the afternoon maintained an adequate standard of record keeping. However, the panel took into account its finding that Registrant C had not prewritten or inaccurately recorded any notes in relation to any of the residents. The panel therefore determined that you had not failed to prevent members of staff prewriting or inaccurately recording notes/records in relation to one, or more, residents as set out in Schedule C 1-6.

Charge 3b

Failed to prevent members of staff prewriting / inaccurately recording notes / records;

b) Generally;

This charge is found not proved.

In reaching this decision, the panel took into account its finding at charge 3a in relation to Schedule C 1-6, that you had not failed to prevent members of staff prewriting or inaccurately recording notes/records generally. The panel therefore could not find charge 3b proved.

Charge 4 a and b

Your conduct at any and / or all of charge 3 above was dishonest in that you:

a) knew that staff had prewritten / inaccurately recorded notes / records;
b) Knew that inaccurate record- keeping was taking place;

This charge is found not proved.

In reaching this decision, the panel took into account its findings at charge 3a in relation to Schedule C 1-6 and 3b. The found that you had not failed to prevent members of staff prewriting or inaccurately recording notes/records. It therefore followed that the panel could not find dishonesty and found charge 4a and 4b not proved.

Charge 5

Failed to make necessary and / or timely referrals in relation to one, or more, residents and / or ensure that such referrals were made by staff:

a) As set out in Schedule D;

Schedule D 1

A referral to the Challenging Behaviour Team following scores of A and B on 9 November 2016

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Individual A, Registrant C and your evidence.

Individual A stated in her evidence *"During Patient A's DST meeting I reviewed the file to gather the evidence necessary to assess Patient A's challenging behaviour. However, I was unable to do so due to the lack information pertaining to the challenging behaviour on the file. For example, there was no referral to the challenging behaviour team, no evidence of one to one recordings with the Patient and no clear documentation of what the Patient was doing which would deem his behaviour to be challenging. These are steps that I would expect to have been taken if there were truly concerns about the Patient's behaviour".*

Your evidence to the panel was that you did make the referral. However, the panel saw no evidence to corroborate that you had.

The panel accepted Individual A's detailed account of her visits to the Home and her checks regarding the referrals. The panel also accepted the evidence of Registrant C that you were responsible for all referrals. She said that you did not let anyone else at the Home deal with referrals and any issues would be escalated to you by staff.

The panel determined, on the balance of probabilities that you had a duty to and failed to make the necessary referrals or ensure that a referral was made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 1 proved.

Schedule D 2

A referral to a dietician / TVN / GP following concerns regarding the residents BMI

This charge is found proved.

In reaching this decision, the panel took into account that your evidence and the evidence of Registrant C and Individual A.

Individual A's evidence was *"During my assessment on 2 June 2017 I noted that Patient B had a BMI of 16 yet there was no evidence on the patients file that a referral had been made to the dietician. I spoke with the GP office to enquire into whether a referral had been made and they confirmed that no referral had been made for Patient B".*

Your evidence to the panel was that you did make the referral to the dietician However, the panel saw no evidence to corroborate that you had. This was contradicted by Individual A.

The panel accepted Individual A's detailed account of her visits to the Home and her checks regarding the referrals. The panel also accepted the evidence of Registrant C that you were responsible for all referrals. She said that you did not let anyone else at the Home deal with referrals and any issues would be escalated to you by staff.

The panel determined, on the balance of probabilities that you had a duty to and failed to make the necessary referrals or instruct that a referral was made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 2 proved.

Schedule D 3

A referral to a dietician in February 2016 following a BMI of 14

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and Registrant C and your evidence.

Witness 6 stated in her evidence *"On review of Patient C's nutritional assessments, I noted that in February 2016 the Patient's BMI was recorded as 14, which is far below the normal range and requires an immediate referral to the dietitian. As noted previously, a BMI which is below 18 is considered abnormally low".*

Your evidence was that anyone with a BMI of less than 18 a referral would have been made but you could not remember this instance.

The panel accepted Witness 6's detailed account of her visits to the Home and her check regarding this referral. The panel also accepted the evidence of Registrant C that you were responsible for all referrals. She said that you did not let anyone else at the Home deal with referrals and any issues would be escalated to you by staff.

The panel determined, on the balance of probabilities that you had a duty to and failed to make the necessary referral to the dietician or instruct that a referral was

made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 3 proved.

Schedule D 4

> *A referral to a dietician from June 2016 onwards and in relation to the residents low BMI generally*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and Registrant C and your evidence.

Witness 6 stated in her evidence *"There is some evidence in the care notes that a dietitian was consulted but this evidence stops from June 2016 onwards until April 2017. In addition, there was an entry by the dietitian in February 2015 that it was not felt that the dietitian recommendations were being implemented and followed. Despite the extremely concerning evidence that Patient C was malnourished, there was no evidence of a referral to the dietitian from June 2016 onwards".*

Your evidence was that anyone with a BMI of less than 18 a referral would have been made but you could not remember this instance.

The panel accepted Witness 6's detailed account of her visits to the Home and her check regarding this referral. The panel also accepted the evidence of Registrant C that you were responsible for all referrals. She said that you did not let anyone else at the Home deal with referrals and any issues would be escalated to you by staff.

The panel determined, on the balance of probabilities that you had a duty to and failed to make the necessary referral to the dietician or instruct that a referral was

made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 4 proved.

Schedule D 5

A referral to a dietician / TVN / GP following the residents BMI being recorded as 16 on 28 April 2017

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Individual A, Registrant C and your evidence.

Individual A's evidence was *"Patient D was the third patient whose folder I reviewed and inspected on 9 May 2017. On looking at the Patient's file I noted that the Patient was recorded on 28 April 2017 to have a Body Mass Index ('BMI') of 16… This is a very low BMI and means that the Patient is at high risk of malnutrition. A healthy person's BMI ranges between 18.5 and 24.9, a BMI of 18.5 requires a referral to a dietitian as it signals that the person is underweight and at high risk of malnutrition".*

She also stated *"I noted that there was a referral criteria document stating that if her BMI fell below 18 a referral needed to be made to the dietitian… In addition, there is national guidance on when a referral to the dietitian should be made... However, despite this document no referral to the dietitian had been made since 2014".*

Your evidence was said that Patient D's relatives said they did not want her to be "too fat" and that she was referred to dietician.

The panel preferred Individual A's detailed account of her visits to the Home and her check regarding this referral. The panel also accepted the evidence of Registrant C that you were responsible for all referrals. She said that you did not let anyone else at the Home deal with referrals and any issues would be escalated to you by staff.

The panel determined, on the balance of probabilities that you had a duty to and failed to make the necessary referral to the dietician or instruct that a referral was made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 4 proved.

Schedule D 6

> *A referral to a GP following a pressure ulcer wound being noted on 25 April 2017*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Individual A

Individual A stated in her evidence "*I would have expected to see a referral to the GP documented in the notes so that pressure wound may have been assessed and the appropriate dressing prescribed. Dressing which is appropriate for the wound is something which must be prescribed by the GP, and therefore whatever dressing was being applied to Patient E wound was dressing available over the counter or which must have been left over from another patient. There was no evidence of a referral to the GP being made in the Patient's notes".*

The panel also had sight of Patient E's care notes.

Your evidence was that unless you know the patient the referrals are of secondary importance. However, you stated that a referral was made.

The panel preferred Individual A's detailed account of her visits to the Home and her check regarding this referral. The panel also accepted the evidence of Registrant C that you were responsible for all referrals. She said that you did not let anyone else at the Home deal with referrals and any issues would be escalated to you by staff.

The panel determined, on the balance of probabilities that you had a duty to and failed to make the necessary referral or instruct that a referral was made by another member of staff to the GP following a pressure ulcer wound being noted. The panel therefore found 5a in relation to Schedule D 6 proved.

Schedule D 7

A referral to a dietician due to the residents low BMI

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Individual A, Registrant C and your evidence.

Individual A stated in her evidence *"On review of Patient E's file, I also noted that Patient E was noted to have a BMI of 18. However, there was no evidence of him being referred to a dietician. On review of my previous checklist for this patient dated 28 February 2017, I noted that I personally referred Patient E to a dietician due to him having a BMI of 16.8."*

In your evidence you said what Individual A said is incorrect regarding the referral. You said that you did make a referral but it took you a month to make it.

The panel preferred to Individual A's detailed account of her visits to the Home and her check regarding this referral. The panel also accepted the evidence of Registrant C that you were responsible for all referrals. She said that you did not let anyone else at the Home deal with referrals and any issues would be escalated to you by staff.

The panel determined, on the balance of probabilities that you had a duty to and failed to make the necessary referral to the dietician or instruct that a referral was made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 7 proved.

Schedule D 8

> *A referral to a dietician which was not made until 22 May 2017 in relation to the residents low BMI*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 3, Registrant C and your evidence.

Witness 3's evidence is that *"I noted that Patient F was admitted to Cheam Cottage with an extremely low BMI of 14 against a weight 41kg, which indicates that the Patient was underweight and malnourished. I am not aware of the exact date that Patient F was admitted to Cheam Cottage, but I recall that the dietician did not*

attend Patient F until 22 May 2017 and that this was some months after the Patient arrived at Cham Cottage."

The panel considered that there was no evidence that a referral was not made until 22 May 2017. The panel took into account that the evidence suggests that the dietician attended on this day, but the panel considered that the referral must have been made prior to this date.

The panel determined that the NMC had not provided sufficient evidence that you had a duty to and failed to make the necessary referral to the dietician before 22 May 2017 or failed to instruct that a referral was made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 8 not proved.

Schedule D 9

> *A referral to a dietician following a low BMI in or around February 2016 / timeously*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6, Registrant C and your evidence.

Witness 6 stated in her evidence *"In July and August 2016 Patient H's body mass index (BMI) was 20 which is within normal range. However, in September to December 2016 there was a decline in the Patient's BMI to 19, following which there was a significant decline to a BMI of 15 in January to May 2017".*

Your evidence was that a referral was made although you accepted it might have taken some time. However, the panel saw no corroborating evidence that the referral was made.

The panel accepted Witness 6's detailed account of her visits to the Home and her check regarding this referral. The panel also accepted the evidence of Registrant C that you were responsible for all referrals. She said that you did not let anyone else at the Home deal with referrals and any issues would be escalated to you by staff.

The panel determined, on the balance of probabilities that you had a duty to and failed to make the necessary referral to the dietician or instruct that a referral was made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 9 proved.

Schedule D 10

> *A referral to a dietician / new care plan following the resident having an aggregate score of 2 for nutritional assessments undertaken between January and June 2017*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence.

Witness 6 stated "*On all of these assessments, there was an aggregate score of two every month which included a score of two for weight loss, meaning that Patient A was having small unintentional weight loss exceeding 0.5 stone in a period of 3 months. This suggests that there was ongoing unintentional weight loss but there is*

no evidence in the records that this weight loss had been acted on. In addition, this nutritional assessment was not the standard Malnutrition Universal Screening Tool ('MUST') and therefore was not in accordance with the National Standard)".

However, the panel noted from the nutritional assessment that there was actually weight gain rather than weight loss and it therefore determined that there was no duty to make a referral. The panel therefore found charge 5a in relation to Schedule D 10 not proved.

Schedule D 11

> *Prior to 20 June 2017, a referral to a TVN despite the resident having a number of wounds*

This charge is found not proved.

In reaching this decision, the panel took into account that you were suspended from your duty as the manager of the Home on 9 June 2017 and would not have been working on 20 June 2017. The panel determined that it could not conclude with certainty that the wounds had been present on this resident prior to you leaving the Home.

The panel determined it could not find that you had a duty to and failed to make the necessary referral to the TVN or that you failed to ensure that a referral was made by staff in relation to this charge at the Home at that time. The panel therefore found charge 5a in relation to Schedule D11 not proved.

Schedule D 12

A referral in relation to the residents normal / abnormal body temperature or breathing rate within the vital signs documentation between December 2016 and May 2017

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence.

Witness 6 stated in her evidence *"The assessments also consistently scored Patient H as a four for breathing, indicating that the Patient had severe difficulty breathing or had oxygen therapy. However, there was no evidence of a care plan on the file to address this need".* She also stated *"The vital signs documentation on Patient H's file also indicated that he consistently had a temperature of 34 or 35°C. This temperature is slightly abnormal with the normal body temperature being around 36 or 37°C. In addition to this, he was noted to have an abnormal breathing rate of 24. However, I could not find any reference to these abnormal results in the daily care records".*

Your evidence to the panel was that you did not consider Patient H's body temperature to be abnormal, so you did not make a referral.

The panel determined that you had a duty to and failed to make the necessary referral and failed to instruct that a referral was made by staff in relation to this charge. The panel therefore found 5a in relation to Schedule D 12 proved.

Charge 5b

Failed to make necessary and / or timely referrals in relation to one, or more, residents and / or ensure that such referrals were made by staff:

b) Generally;

This charge is found proved

In reaching this decision, the panel had regard to the wording of the charge. It could only be satisfied that there had been a general failure if a significant number of the charges, in Schedule D was found proved. In reaching this decision, the panel took into account its finding at charge 5a in relation to Schedule D 1, D 2, D 3, D 4, D 5, D 6, D 7, D 9 and D 12. It determined that because the failures found proved were broad in nature and involved multiple residents, it was satisfied that you failed, generally, to make necessary and / or timely referrals in relation to one, or more, residents and / or ensure that such referrals were made by staff generally. The panel therefore found charge 5b proved.

Charge 6a

Failed to have appropriate / due regard to the changing dietary / health needs of one, or more, residents and / or ensure that appropriate regard was had to such needs:

a) As set out in Schedule E

Schedule E 1

The residents need for a halal diet

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Individual A, Witness 3 and your evidence.

Individual A stated in her evidence *"During my conversation with him, Patient A told me that he needed to be on a halal diet. Whilst this was noted on one page of the care plan, not all documentation in the file was conducive to him receiving a halal diet".*

Witness 3 stated *"I went to speak to the cook to enquire about Patient A's special dietary needs. However, the cook told me that she was not aware of any residents with dietary requirements other than Patient F. Therefore, I was concerned as the cook's response seemed to confirm that Patient A was not being fed a diet which was appropriate for his religious belief. Feeding a patient a diet which is contrary to his cultural and religious beliefs is completely unethical".*

In your evidence you said this resident would not eat and couldn't chew. You said he wanted milk and pasta which is what you provided.

The panel considered that as the registered manager of the Home you had the responsibility to ensure set menus were in place for the residents and relay any information to the kitchen to ensure dietary needs were met. The panel determined that you failed to have appropriate/due regard to the changing dietary/health needs and failed to ensure that appropriate regard was had to such needs. The panel therefore found charge 6a in respect of Schedule E 1 proved.

Schedule E 2

> *The residents dislike of vegetables and the fact that they continued to be fed such items*

This charge is found proved.

In reaching this decision, the panel took into account Individual A's evidence and your evidence.

Individual A stated in her evidence *"While reviewing Patient B's file, I noted that there was a piece of documentation which noted the patients likes and dislikes. The patient was noted to like boiled potatoes, sausages, eggs, porridge and English food. He was noted to dislike vegetables, fish and chips. Upon reading this document, I requested to see Patient B. The patient was eating lunch at this time. I observed that there were boiled potatoes, sausages and half a plate of vegetables. I was concerned as the patient was given vegetables even though he was noted to dislike them, and this reinforced the dietary concerns noted above that no regard was given to the patient's dietary requirements or preferences..."*

You told the panel in your evidence that you do not know why this resident was served vegetables.

The panel considered that as the registered manager of the Home you had the responsibility to ensure set menus were in place for the residents and relay any information to the kitchen to ensure dietary needs were met. The panel determined that you failed to have appropriate/due regard to the changing dietary/health needs and failed to ensure that appropriate regard was had to such needs. The panel therefore found charge 6a in respect of Schedule E 2 proved.

Schedule E 3

The residents care plan dated 18 May 2016 did not contain reference to the dieticians recommendations / the residents weight loss / and contained vague and insufficient information

This charge is found proved.

In reaching this decision, the panel took into account Registrant C's, Witness 6's evidence and your evidence.

Witness 6 said in her evidence *"There was a nutrition care plan in place dated 18 May 2016; however this did not reference the dietitian recommendations and overall contained vague, insufficient and contradictory information".*

Registrant C said in her evidence that she did not know about the dietician's recommendations and could not take them into account as you did not tell her that the letter had arrived. The panel also heard from multiple witnesses that you 'micromanaged' the Home and the nurses had 'no power', did not run the shifts and were not fully responsible for patient care.

You told the panel that the nurses know the residents and will eat what they want and this might not be reflected in the care plan.

The panel was of the view that you did not implement the dietician's recommendations into the residents care plan and you did not share the recommendations with staff in the Home to ensure that they could have due regard to the resident's needs. The panel therefore found charge 6a in respect of Schedule E 3 proved.

Schedule E 4

The residents weight loss / sufficient detail regarding the residents diet / meal requirements / supplements

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence *"When attempting to compare this scoring with the actions taken in the care notes to address these risks, there was no record of any action taken in the care notes to evidence that the observation of consistent weight loss was being acted upon".*

The panel considered this with respect of Resident E and had sight of the dietician's letter and saw no evidence that Resident E had lost weight. The panel considered that you had no duty to take action as there was no evidence of weight loss. The panel therefore found charge 6a in respect of Schedule E 4 not proved.

Schedule E 5

The residents need for a vegetarian diet / the recommendation by the dietician for cheese and cream to be added to the residents diet

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 3, Registrant C and you.

Witness 3's evidence was *"On my visit on 2 June 2017, there was confusion amongst staff members as to whether the Patient was actually a vegetarian and*

whether she had been placed on a vegetarian diet. The Registrant informed me that Patient F had not been placed on a vegetarian diet due to Patient F's friend informing him that Patient F was not really a vegetarian".

Registrant C's evidence was that there was no clear understanding as to whether this resident was vegetarian, and you were not advised she was vegetarian when she arrived. The panel saw no evidence of this resident's need for a vegetarian diet.

Your evidence was that this resident was vegetarian many years ago prior to having dementia and was not a vegetarian at the time of being admitted to the Home. You stated that the resident was admitted to you from hospital and was not served a vegetarian diet in hospital.

With regard to the dietician's recommendations, the panel noted that these were received on the 22 May 2017. The panel saw no evidence that you saw these recommendations or that the care plan was reviewed after that date.

The panel accepted your evidence and determined that there was insufficient evidence to demonstrate a failure. The panel therefore found charge 6a in respect of Schedule E 5 not proved.

Schedule E 6

> *The residents weight loss following and aggregate score of 2 for the nutritional assessments undertaken between January and June 2017 / generally*

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6.

Witness 6 stated in her evidence that *“On all of these assessments, there was an aggregate score of two every month which included a score of two for weight loss, meaning that Patient A was having small unintentional weight loss exceeding 0.5 stone in a period of 3 months. This suggests that there was ongoing unintentional weight loss but there is no evidence in the records that this weight loss had been acted on. In addition, this nutritional assessment was not the standard Malnutrition Universal Screening Tool ('MUST') and therefore was not in accordance with the National Standard)”.*

However, the panel noted from the nutritional assessment that between January and June 2017 his weight stabilised, and his BMI remained at 15 and it therefore determined that there was no duty to take any further action during the period of time in question. The panel noted that a significant weight loss occurred for this resident prior to these dates. The panel therefore found charge 6a in relation to Schedule E 6 not proved.

Schedule E 7

> *The residents needs for nutritional supplements / meal enhancements required*

This charge is found not proved.

In reaching this decision, the panel took into account Witness 6’s evidence.

Witness 6 stated in her evidence *“The care plan should have detailed whether additional nutritional supplements were required, whether the Patient’s meals were*

being enhanced with calories, protein and fat, and finally to include the details of the specialist opinion".

The panel saw no evidence of the residents need for nutritional supplements. The panel considered that the NMC had not produced sufficient evidence to find this charge proved. The panel therefore found charge 6a in relation to Schedule E 6 not proved.

Schedule E 8

The residents skin deterioration

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence

Witness 6 stated *"On 20 June 2017, tissue viability nurse (TVN) carried out a full assessment of Patient H"*

Your evidence is that you were suspended at that time.

The panel took into account that you had been suspended from your duty as the manager of the Home on 9 June 2017 and would not have been working on at the time of the assessments. The panel was not shown any compelling evidence that the wounds noted in the assessment were visible on 9 June 2017. The panel determined that you were not responsible for the care plans for the resident's pressure sores or for ensuring that such documentation was completed by staff at the Home at that time. The panel therefore found charge 6a in relation to Schedule E 8 not proved.

Charge 6b

Failed to have appropriate / due regard to the changing dietary / health needs of one, or more, residents and / or ensure that appropriate regard was had to such needs:

b)Generally

This charge is found proved.

In reaching this decision, the panel had regard to the wording of the charge. It could only be satisfied that there had been a general failure if a significant number of the charges, in Schedule E was found proved. The panel took into account its finding at charge 6a in relation to Schedule E 1, E 2 and E 3. It determined that because the failures found proved were broad in nature and involved multiple residents, it was satisfied that you failed, generally, to have appropriate or due regard to the changing dietary / health needs of one, or more, residents and/or ensure that appropriate regard was had to such needs. The panel therefore found charge 6b proved.

Charge 7

On 9 May 2017:

a) *Failed to intervene when one, or more, members of staff shouted at Individual A who was enquiring about food being fed to a patient;*
b) *Joined in with the events referred to in charge 7(a) above;*
c) *Laughed at Individual A when she asked about the soup being provided to residents;*

This charge is found proved.

In reaching this decision, the panel took into account your evidence and Individual A's evidence.

Your evidence to the panel was that Individual A was in the wrong with regard to this incident. You accepted that this incident took place. However, you said that it was Individual A who shouted and whose behaviour was unacceptable. You stated that a resident's relative complained about individual A's behaviour. However, you did accept that an altercation took place between you, your staff and Individual A.

The panel noted a letter where Individual A appeared to acknowledge her behaviour and she *"has agreed her reaction to the situation was an error of judgment and conduct and not to the standard that is expected by the CCG".*

The panel considered that as a matter of fact you failed to intervene and were involved in the verbal altercation with Individual A. The panel determined on the balance of probabilities that you also laughed at Individual A when she asked about the soup being provided to residents and that this incident did occur as alleged in the charges. The panel therefore found charge 7a, 7b and 7c proved.

Charge 8

> *Your conduct at any and / or all of charge 7 above, took place in front of residents at the Home and/or was inappropriate;*

This charge is found proved.

In reaching this decision, the panel took into account that it found that the incident did occur at the Home.

Your evidence was that the incidents in charge 7 took place in an area where residents were present. The panel determined that your conduct was inappropriate. Therefore, the panel found charge 8 proved.

Charge 9

Failed to ensure that correct procedures and protocols were carried out in relation to the use of controlled drugs at the Home

No case to answer

Charge 10

Failed to ensure that the Deprivation of Liberty Safeguards ('DoLS') procedure was followed in relation to one, or more, residents;

No case to answer

Charge 11

Your conduct / failings at any and/or all of the charges referred to above resulted in a preliminary decision to advise all Local Authorities with placements to move residents out of the Home and/or the voluntarily closure of the Home, resulting in one, or more, residents having to be moved.

This charge is found proved.

In reaching this decision, the panel took into account its finding of multiple failures in relation to wide ranging issues concerning multiple residents at the Home. The panel determined that, as a matter of fact, and as a consequence of your conduct/failings at any and/or all of the charges referred to above resulted in a preliminary decision to advise all Local Authorities with placements to move residents out of the Home and/or the voluntarily closure of the Home, resulting in one, or more, residents having to be moved. The panel therefore found charge 11 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 amounted to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, 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 had to determine whether the facts found proved amounted to misconduct. Secondly, only if the facts found proved amounted to misconduct, the panel had then to decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Mohamed invited the panel to take the view that the facts found proved did amount to misconduct. She referred the panel to 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Ms Mohamed identified the specific relevant standards where, in the NMC's view, your actions amounted to misconduct. She submitted that the charges found proved involved widespread concerns and also involved managerial responsibilities and attitudinal issues. She submitted that the incidents were not isolated and covered period of time when you were responsible for running the Home. She submitted that your actions were sufficiently serious to warrant misconduct.

Ms Mohamed moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). (Grant)

Ms Mohamed referred the panel to the bundle of documents including references and training certificates you provided for this hearing. She observed that the certificates date back to 2019 but there is nothing up to date as of 2022.

Ms Mohamed submitted that as of today's date there is limited information before the panel as to how you have kept your knowledge and skills up to date and how you have remediated the concerns in the charges found proved.

Ms Mohamed submitted that your conduct involved multiple and vulnerable residents

within a nursing home setting. You were in a position of authority and your actions fell short of the standards expected of registered manager. She invited the panel to make a finding of current impairment on the grounds of public protection and public interest.

You reminded the panel that the NMC has not allowed you to work for five years, and you indicated that you believe this to be unfair. You said you have not provided up to date references or evidence of what you have done in relation to strengthening your practice since you have not been able to work in a health setting and any other work would not be relevant to this hearing. You informed the panel that you have worked in the catering industry.

You told the panel that you had undertaken various training courses over the last few years in dementia, first aid, food hygiene and other “normal nursing training”. You said you have also undertaken training in safeguarding and record keeping. You said that the training certificates could be made available to the panel, and you were requested to provide them.

You said that people who have not worked in an advanced dementia care home setting would not be able to understand the environment. You said as registered manager your main job was to deal with finances not the care of residents and you relied on the other registered nurses. On reflection you said that you could have been more careful to ensure that the work carried out by other nurses was up to standard.

You told the panel that you do not have to be a registered nurse to be a home manager so you do not know why your registration has been affected. You said you accepted your failures as a registered manager but not as nurse. You submitted that your fitness to practice is not impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Ronald Jack Cohen v General Medical Council* [2008]

EWHC 581 (Admin) and *Ahmedsowida v GMC* [2021] EWHC 3466 (Admin)[95] – [113].

Decision and reasons on misconduct

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

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

> *"1.2 make sure you deliver the fundamentals of care effectively*
>
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> *2.1 work in partnership with people to make sure you deliver care effectively*
>
> *3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*
>
> *6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services*
>
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> *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*

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 health and care 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

9.1 provide honest, accurate and constructive feedback to colleagues

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

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

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

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

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

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

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

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

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

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

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

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

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

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

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

The panel considered that it should look at each charge separately and consider whether each charge individually amounted to misconduct. It did not consider all of the charges on a cumulative basis.

However, the panel was of the view that in relation to charge 1, the aspects of Schedule A found proved related to wide-ranging issues in respect of record keeping and documentation of care plans, daily care notes, wound assessments and meal plans. The panel considered that the quality of record keeping at the Home was generally of a poor standard. As registered manager you were overall responsible for providing correct forms, monitoring and auditing records and ensuring an adequate standard of record keeping was maintained by staff and your failures put residents at risk of harm. The panel found that your actions in charge 1 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In relation to charge 2, the panel considered that the aspects of Schedule B found proved were serious and related to failing to document wounds, bruises and dietary needs appropriately. The panel considered that the quality of documentation in relation to wounds, bruises and dietary needs at the Home was generally of a poor standard. As registered manager you had overall responsibility for monitoring and auditing records to ensure that such documentation was undertaken by staff and your failures put residents at risk of harm. The panel accepted that you generated a culture of working where you retained full responsibility for wound care and ‘micromanaged’ the staff at the Home. The panel found that your actions in charge 2 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In relation to charge 5, the panel considered that the aspects of Schedule D found proved were serious and related to failing to make necessary referrals and ensuring that such referrals were made by staff. The panel accepted that you generated a culture of working where you retained full responsibility for making referrals and

‘micromanaged’ the staff at the Home. This prevented specialists from accessing the residents and caused a delay in care which put them at unwarranted risk of harm. The panel found that your actions in charge 5 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In relation to charge 6, the panel considered that the aspects of Schedule E found proved were serious and related to your failure to have due regard to religious beliefs, dislike of certain foods and dietician’s recommendations for one or more residents at the Home. You demonstrated a lack of due regard and respect for these residents as individuals and put them at risk of suffering harm. The panel found that your actions in charge 6 fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In relation to Charge 7 and 8, the panel considered that you demonstrated inappropriate behaviour in that you should have tried to intervene to de-escalate the situation involving Individual A. The panel took into account that Individual A accepted that she had also behaved inappropriately and apologised. The panel formed the impression that this unfortunate episode was an isolated incident that lasted a short period of time. It took place in the presence of residents and their relatives. The panel considered whether this was sufficiently serious to amount to misconduct. The panel considered that although your behaviour in respect of charge 7 and 8 amounted to a breach of the code it was not so serious to amount to misconduct.

In relation to charge 11, the panel considered that the decision that was taken to close the home was as a result of the longstanding issues at the Home. Although the charges found proved were the precipitating factor, in the closure of the home, the panel could not identify any aspect of the code that could be correlated to this charge. A registered nurse is entitled to own, manage and operate a nursing home. The operation of a nursing home is regulated by a separate regulator. In all the circumstances the panel was not satisfied that the circumstances in charge 11 specifically amounted to misconduct.

The panel found that your actions in relation to each of the charges 1, 2, 5 and 6 did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

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

In this regard the panel considered the "test" of Mrs Justice Cox in the case of *CHRE v NMC and Grant* para 76:

> *'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 found limbs a – c engaged in the *Grant* test. The panel found that residents in your care were put at risk and potentially caused physical harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel heard and accepted further Legal advice from the Legal Assessor. He referred to the cases of *Ahmedsowida v GMC ; GMC v Awan [2020] EWHC 1553 (Admin)* and *Towuaghantse v GMC [2021] EWHC 681 (Admin) [61-63].*

The panel noted that in your submissions you sought to blame others instead of taking responsibility for the issues at the Home. You have not demonstrated an understanding of how your actions put residents at a risk of harm or demonstrated an understanding of why what you did was wrong. The panel also considered that you have not sufficiently demonstrated how you would handle the situation differently in the future or how your misconduct impacted negatively on your colleagues and the reputation of the nursing profession.

The panel accepted that it would not be procedurally fair and unrealistic to expect you to accept its findings of fact having defended the charges for some considerable period of time. The panel did not consider that it would be fair to consider this to be a factor in determining current impairment.

The panel was more concerned about what, if any remediation you had undertaken. Even if you had contested all of the charges you could still have undertaken courses and wider reading to demonstrate that there should be no current concern regarding your fitness to practise.

The panel was satisfied that the misconduct in this case was theoretically capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not you have taken steps to improve your practice. The panel had regard to a number of courses that you had completed but they dated back to 2019.

As a registered nurse you would be expected to continue to attend courses and conduct wider reading.

The panel took into account that you said in your submissions that you had undertaken various training courses to keep your knowledge and skills up to date, but it was not provided with any further certificates or documentary evidence of steps you have taken to strengthen your practice. In the absence of any documentary evidence the panel could not be satisfied that you had taken any steps to address the various regulatory concerns found proved. The panel could not accept your vague submissions that you had attended “normal nursing” courses in the absence of concrete proof that you had done so.

You also told the panel that anything you have done would not be relevant to nursing as you have been unable to work as a nurse. You explained to the panel that you have been the subject of a lengthy interim suspension order. You said that you could not work in the care setting as your suspension would be a reason for not employing you. The panel was not presented with any documentary evidence of your attempts to find work or volunteer in a care setting.

The panel is of the view that there is a high risk of repetition based on the absence of any documentary evidence that you have strengthened your practice. The failure to produce this evidence also demonstrates a lack of insight. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Mohamed informed the panel that the NMC's sanction bid was a striking off order and she outlined to the panel what the NMC considered were the aggravating and mitigating features of the case.

Ms Mohamed submitted that to take no further action or to impose a caution order would not be appropriate or proportionate taking into account the risk of repetition identified, would not protect the public nor would it satisfy the public interest considerations. She asked the panel to consider whether a workable conditions of practice order could be formulated to address the wide ranging concerns identified and whether it considered that you would respond to retraining.

In relation to a suspension order, Ms Mohamed submitted that this was not a single instance of misconduct and occurred over a period of time. She submitted that the

panel had identified attitudinal concerns and a risk of repetition, and a suspension order was not the appropriate and proportionate order in this case. She submitted that the appropriate order in this case is a striking-off order as your misconduct is fundamentally incompatible with remaining on the register.

You submitted to the panel that you are a mental health nurse and unless you have worked with people with advanced dementia you could not understand how it is. You said you allocated wound care to other nurses at the Home and they should not have blamed you. You stated that the physical needs of the residents were not your role. You said referrals to dieticians were done eventually although it took some time. You said referrals for advanced dementia patients were not straight forward. You said that there were never complaints from the relatives of the residents. You said that you took in residents that other homes had refused.

You said that the NMC should not have imposed an interim suspension order you for five years but you have still kept your knowledge and skills up to date. You asked the panel to consider the 50 years you have worked as a mental health nurse and give you the chance to start again and give you the opportunity to return to nursing. You said you would agree to retrain in mental health nursing, and outlined the types of roles you would like to take on. You said you would accept supervision if the panel decided that. You said that you had looked at some colleges about returning to practice and hope the panel will give you the opportunity to retrain.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The

panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Your lack of insight which has remained unchanged throughout the hearing
- A pattern of misconduct over a period of time
- Your misconduct put residents at risk of suffering harm and caused actual harm
- Your misconduct was wide ranging and involved numerous vulnerable residents
- You have demonstrated serious attitudinal issues
- Your senior position as the registered manager of the Home and as a registered nurse which meant you had oversight of all clinical needs of residents at the Home.

The panel also took into account the following mitigating features:

- You told the panel that the Home had financial problems which took up a lot of your time as manager, although the panel saw no evidence of this.

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 not protect the public nor be in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel

decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the widespread nature of the charges in this case. The panel noted that although you had said that you are willing to retrain there is no evidence that you have undertaken any training since 2019. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel considered that your misconduct was widespread and involved multiple residents. You demonstrated throughout the hearing serious attitudinal concerns. The panel took into account that you had not been able to work in the five years since the charges arose but had found that there was a risk of you repeating your conduct due to the lack of insight you have demonstrated.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious

breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, 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 and conduct required of a registered nurse.

This decision will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Mohamed. She submitted that an interim suspension order for 18 months is necessary on the grounds of public protection and in the wider public interest to cover the period of appeal.

You said you will be making an appeal. You said it is unfair for the NMC to have stopped you from working for five years and you told the panel about the financial hardship you have suffered. You said all the blame was put on you which was wrong.

Proceeding in absence

After the panel heard submissions for the interim order application, Mr Dudhee told the panel that he did not want to participate in the hearing any longer and ended the

telephone call. Attempts were made to call him back into the hearing but the telephone calls were not answered.

Ms Mohamed made an application to proceed in the absence of Mr Dudhee. She submitted that the panel had heard his submissions on the interim order application and reminded it that Mr Dudhee would be sent the decision for the application by email and by post. Ms Mohamed therefore invited the panel to proceed in Mr Dudhee's absence

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

The panel considered there is a strong public interest in the expeditious disposal of the case. In these circumstances, the panel decided that it was fair, appropriate and proportionate to proceed in the absence of Mr Dudhee in order to hand down its decision on the interim order application and to conclude the case.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period. The panel had regard to the issue of proportionately. It appreciated that an interim suspension order would prevent Mr Dudhee from working but considered that

the public protection issues it identified outweighed his right to work in his chosen profession.

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

That concludes this determination.