Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

[Split Hearing]
9, 10, 13-17, 20-24, 27 and 28 November 2023
4-8, 11-15 and 18-20 December 2023

Virtual Hearing

Name of Registrant:	**Margaret Anne Kelliher**
NMC PIN	72A0749E
Part(s) of the register:	Registered Nurse – RN1: Adult Nursing (October 1997) Registered Nurse – RN2: Adult Nursing (February 1973)
Relevant Location:	London Borough of Islington
Type of case:	Misconduct
Panel members:	Paul O'Connor (Chair – Lay member) Alex Forsyth (Lay member) Sharon Peat (Registrant member)
Legal Assessor:	Suzanne Palmer Monica Daley from 4 December 2023 John Moir from 18 December 2023
Hearings Coordinator:	Vicky Green Elizabeth Fagbo on 13 December 2023
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Mrs Kelliher:	Not present and not represented in her absence
Facts proved:	Charges 1.a), 1.b), 1.c), 2, 3.b), 3.c), 3.d), 4.a), 4.b), 4.c), 5.a), 5.b), 5.c), 5.d), 6, 7.a), 7.b), 8.a), 8.b), 9, 10.a), 10.b), 10.c), 10.d), 10.e), 10.f), 10.g), 11, 12.a), 12.b), 12.c), 12.d), 12.e), 12.f),

	12.g), 13.a), 13.b), 13.c), 13.d)i., 13.d)ii.,14, 15.a), 15.b), 16, 17, 18, 19, 20.a), 20.b), 21.a), 21.b)i., 21.b)ii., 21.c)i., 21.c)ii., 21.d), 21.e), 21.f), 21.g), 21.h), 22.a), 22.b), 23.a), 23.b), 25, 26.a), 26.b), 26.c), 28.a), 28.b), 28.c), 28.d), 29
Facts not proved:	Charges 3.a), 20.c), 24.a), 24.b), 27
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Kelliher was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 11 October 2023.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Kelliher

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

Mr Kennedy drew the panel's attention to the proceeding in absence bundle which contained two email communications from Mrs Kelliher to the NMC dated 6 October 2023. In these emails, Mrs Kelliher stated that she would not be attending the hearing and that she was happy for the hearing to proceed in her absence. Mr Kennedy submitted that an adjournment would serve no useful purpose as Mrs Kelliher had

voluntarily absented herself. He submitted that it was in the interests of justice to proceed in the absence of Mrs Kelliher.

The panel has decided to proceed in the absence of Mrs Kelliher. In reaching this decision, the panel has considered the submissions of Mr Kennedy, the emails from Mrs Kelliher and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones (Anthony William) (No.2) [2002] UKHL 5* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Kelliher.
- Mrs Kelliher has informed the NMC that she has received the Notice of Hearing and confirmed she is content for the hearing to proceed in her absence.
- There is no reason to suppose that adjourning would secure her attendance in the future.
- Six witnesses have made themselves available to give evidence at this hearing.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.
- The charges relate to events that occurred in 2019.
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Kelliher in proceeding in her absence. Mrs Kelliher will not be able to challenge the evidence relied upon by the NMC and she will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Kelliher's decision to absent herself from the hearing, waive her

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

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

Details of charge (as amended)

That you, a Registered Nurse, whilst employed as the Deputy Home Manager and Clinical Lead at The Highgate (the 'Home'):

1. Did not ensure action plans were always
    a) Reviewed **[Proved]**
    b) signed off. **[Proved]**
    c) followed up on. **[Proved]**

2. Demonstrated poor engagement with external professionals. **[Proved]**

3. Did not ensure care plans were:
    a) In place for all residents **[Not proved]**
    b) Updated for residents when required. **[Proved]**
    c) Regularly reviewed **[Proved]**
    d) Person centred **[Proved]**

4. In relation to Patient V did not:
    a) Ensure that their challenging behaviour was documented. **[Proved]**
    b) Ensure evidence of nursing need was recorded. **[Proved]**
    c) Take steps to ensure the appropriate information was recorded to support their funding. **[Proved]**

5. Did not ensure that where necessary, risk assessments were:
    a) in place. **[Proved]**
    b) complete **[Proved]**
    c) reviewed **[Proved]**
    d) been consistently followed by staff. **[Proved]**

6. Did not ensure 'Resident of the Day' reviews were taking place monthly for all residents. **[Proved]**

7. Did not ensure Daily Clinical Walk Rounds were:
    a) carried out consistently **[Proved]**

b) Were properly recorded on the relevant form. **[Proved]**

8. Did not ensure the 'My Portrait' tool for each resident was:

a) Complete or **[Proved]**
b) Completed accurately **[Proved]**

9. Did not ensure medication protocols were consistently implemented adequately or at all. **[Proved]**

10. Did not ensure medication:

a) Was securely stored when not in use **[Proved]**
b) Was disposed of properly when no longer required. **[Proved]**
c) Was properly recorded as received. **[Proved]**
d) Was labelled with opening dates. **[Proved]**
e) Stock levels were monitored and/or recorded. **[Proved]**
f) Was delivered to the Home in time to avoid residents missing doses. **[Proved]**
g) Was being administered according to the prescription **[Proved]**

11. Did not adequately assess staff competency in relation to medication administration/practice. **[Proved]**

12. Did not take steps to ensure the security and safety of the Residents in that:

a) Treatment rooms were not locked when not in use. **[Proved]**
b) Sluice rooms were not locked when not in use. **[Proved]**
c) Fire exits were not clear. **[Proved]**
d) Waste management sheets were not in place. **[Proved]**
e) There were no working pagers in the Home. **[Proved]**
f) You did not ensure incidents were being recorded on DATIX **[Proved]**
g) Oxygen cylinders were being stored in clinical rooms and not outside. **[Proved]**

13. Did not ensure that

a) Up-to-date Topical Medication Administration Records ("TMAR") forms were being used. **[Proved]**
b) TMARs were being completed or correctly completed by the nursing staff. **[Proved]**
c) The MAR charts front sheets were the same on each floor of the Home **[Proved]**
d) Medication charts were
    i. being signed **[Proved]**
    ii. completed fully and/or properly. **[Proved]**

14. Did not take immediate action to replace Resident A's broken humidifier **[Proved]**

15. Did not effectively
    a) Communicate new policies and/or paperwork produced by BUPA to the relevant staff. **[Proved]**
    b) Implement procedure and policy. **[Proved]**

16. Did not ensure thickener was being used appropriately in the Home. **[Proved]**

17. Did not ensure food and fluid changes were being regularly and/or accurately updated. **[Proved]**

18. Did not ensure updated Speech and Language Therapy ("SALT") descriptors were being used. **[Proved]**

19. Did not ensure that the information being provided to the kitchen for food preparation matched the risk matrix in relation to SALT. **[Proved]**

20. With regards resident's wounds, did not ensure
a) Plans were put in place following visits from the Tissue Viability Nurse. **[Proved]**
b) Care was properly documented. **[Proved]**
c) Safeguarding concerns were raised. **[Not proved]**

21. In relation to Patient C

a) A wound which had been present since 2013 was being dressed with Inadine which is inappropriate for long term use. **[Proved]**
b) The use of Inadine:
    i. was not documented on their medication chart **[Proved]**
    ii. Had not been prescribed **[Proved]**
c) In the wound assessment chart there was
    i. No documented evidence **[Proved]**
    ii. No measurement of the wound **[Proved]**
d) No wound management care plan in place **[Proved]**
e) No photographic evidence of the wound in the patient's notes **[Proved]**
f) No evidence of the wound being reviewed by a relevant professional **[Proved]**
g) No evidence that a referral to a Tissue Viability Nurse had been made. **[Proved]**
h) Did not make a timely referral to Speech and Language when he reported coughing when eating. **[Proved]**

22. In relation to Patient W did not respond adequately to concerns raised by Nurse A and Patient W's niece that Patient W was scared of a male night nurse on 10 April 2018 in that

a) No reassurance was given that you would look into the issue. **[Proved]**
b) Did nothing to investigate the concerns raised. **[Proved]**

23. Did not ensure confidential information was

a) Kept in cabinets which were locked **[Proved]**
b) Not left unattended **[Proved]**

24. Did not ensure staff:

a) Took their breaks in designated staff areas. **[Not proved]**
b) Did not use their personal phones whilst on duty. **[Not proved]**

25. Did not ensure the DOLS tracker was up to date and/or accurate. **[Proved]**

26. Did not ensure the forms for capacity and/or best interest decisions were being completed correctly in that they

a) Were not person centred **[Proved]**
b) Did not specify the Key Decision that had been made **[Proved]**
c) Lacked detailed reasoning as to why a decision was in the resident's best interests. **[Proved]**

27. Did not take steps to promote communal activities for the residents. **[Not proved]**

28. In relation to safeguarding:

a) You did not consistently use the safeguarding tracker **[Proved]**
b) Did not consistently report concerns/incidents. **[Proved]**
c) Did not follow the appropriate processes. **[Proved]**
d) Did not complete action points following safeguarding meetings. **[Proved]**

29. Did not demonstrate that you took seriously concerns raised. **[Proved]**

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

Decision and reasons on application to amend the charges

After the charges were read, the panel heard an application made by Mr Kennedy to amend the wording of charges 4.c) and 23.b). This application was made pursuant to Rule 28 of the Rules.

Charge 4.c) originally read:

> 4. In relation to Patient V did not:
>
> c)Take steps to ensure the appropriate information was recorded so support their funding.

The proposed amendment to charge 4.c) was as follows:

> 4. In relation to Patient V did not:
>
> c)Take steps to ensure the appropriate information was recorded ~~so~~ to support their funding.

Mr Kennedy submitted that this charge as it originally read does not make grammatical sense. He submitted that the proposed amendment would ensure that this charge reads correctly.

Charge 23.b) originally read:

> 23. Did not ensure confidential information was
>
> b) Left unattended

The proposed amendment to charge 23.b) was as follows:

> 23. Did not ensure confidential information was
>
> b) Not left unattended

Mr Kennedy submitted that charge 23.b) as it originally read is missing the word ‘not’ and that the proposed amendment would clarify the charge.

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

The panel was of the view that such amendments were in the interests of justice. The panel was satisfied that both proposed amendments were simply correcting what were clearly typographical errors in the charges. It was clear from the context of the charges that they were intended to be read in line with the proposed amendments. It noted that Mrs Kelliher had not responded to the charges and had therefore not indicated any challenge to the substance of either charge in respect of which an application was made. Although the panel acknowledged that she was not on notice of the proposed amendments, that was as a result of her decision to absent herself from the proceedings. In all the circumstances, the panel considered that, allowing the proposed amendments would therefore cause no prejudice or unfairness to either party, and would be in the interests of justice. Accordingly, the panel determined that it was appropriate to allow the amendments to ensure clarity and accuracy.

Decision and reasons on application to adduce further witness statements

During hearing oral evidence from Ms 4, it came to light that she had prepared a witness statement specifically for Mrs Kelliher.

The panel noted that in the joint witness statement bundle, at the top of each of the witness statements, it is stated that the witness statement was produced in respect of Colleague A.

Having heard that Ms 4 produced another witness statement for Mrs Kelliher, the panel invited submissions on whether this should be admitted into evidence, and whether other similar witness statements would be available to the panel.

Mr Kennedy informed the panel that witness statements had been produced for Colleague A and for Mrs Kelliher, however as these statements were very similar, the

NMC prepared a joint witness statement bundle containing the witness statements for Colleague A. He submitted that as there is overlap in this case, the witness statements for Colleague A also cover the issues and charges relating to Mrs Kelliher. Mr Kennedy submitted that both the joint witness statement bundles and the witness statement bundle specific to Mrs Kelliher have been provided to her prior to this hearing.

Mr Kennedy submitted that the panel should have been provided with the witness statements produced for Mrs Kelliher and made an application for this bundle to be admitted into evidence pursuant to Rule 31 of the Rules. He submitted that the panel has a discretion to admit this evidence and that it would be fair and appropriate to do so.

The panel accepted the advice of the legal assessor.

The panel bore in mind that Mrs Kelliher had previously been provided with the witness statement bundle. It was of the view that the evidence contained within the additional witness statement is relevant and given that Mrs Kelliher has had sight of them, it would be fair to admit this further evidence at this stage.

Decision and reasons on application to amend charge 17

Mr Kennedy made an application to amend the wording of charge 17, this application was made pursuant to Rule 28 of the Rules.

Charge 17 originally read:

> 17. Did not ensure food and fluid charges were being regularly and/or accurately updated.

The proposed amendment to charge 17 was as follows:

> 17. Did not ensure food and fluid changes were being regularly and/or accurately updated.

Mr Kennedy submitted that this charge contains a typographical error and contains the word ‘charges’ instead of ‘changes’. He submitted that the proposed amendment does not change the substance of the charge and can be made without any prejudice to Mrs Kelliher.

The panel accepted the advice of the legal assessor.

The panel decided to grant this application. It determined that as the proposed amendment is to correct a typographical error, it does not change the substance of the charge and causes no injustice to Mrs Kelliher.

Decision and reasons on application to admit the witness statement of Ms 7

After hearing evidence from all of the NMC witnesses, Mr Kennedy made an application for the witness statement of Ms 7 to admitted into evidence as hearsay. This application was made pursuant to Rule 31 of the Rules. Mr Kennedy referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*.

Mr Kennedy informed the panel that since providing the NMC with a witness statement, Ms 7 has passed away. He drew the panel’s attention to a Trace Report that confirmed that Ms 7 had since died.

Mr Kennedy submitted that the evidence contained in Ms 7’s witness statement is relevant to the charges. He also submitted that the evidence of Ms 7 is not the sole or decisive evidence in this case. Mr Kennedy submitted that Mrs Kelliher had decided to not take part in the hearing and not responded to the charges meaningfully. He submitted that there is no reason for Ms 7 to have fabricated her witness statement, she had no prior dealings with the care home or either registrant before making her findings during a visit carried out as part of her role as a Risk and Governance inspector at BUPA.

Mr Kennedy submitted that Ms 7’s evidence is supported by other witness evidence. He submitted that the charges are serious, both individually and cumulatively and may have

an adverse impact on Mrs Kelliher's registration if found proved. Mr Kennedy submitted that there is a good reason for Ms 7's non-attendance. He submitted that prior to this hearing, Mrs Kelliher was informed that the NMC was going to make this application. Mr Kennedy submitted that taking all of the above into account, there would be no unfairness if the witness statement of Ms 7 was admitted into evidence as hearsay.

The panel accepted the advice of the legal assessor.

In reaching this decision, the panel had regard to Mr Kennedy's submissions, Rule 31 of the Rules, the principles set out in the case of *Thorneycroft* and the NMC Guidance on the admissibility of evidence and hearsay (Reference DMA-6 Last updated 01/07/2022).

The panel determined that the witness statement of Ms 7 is relevant to the charges, but it was not the sole or decisive evidence. In these circumstances, it is not possible for Ms 7 to attend the hearing. The panel was of the view that there was no reason for Ms 7 to fabricate her evidence. The panel noted that Mrs Kelliher was put on notice of this application and did not object to it. Having regard to all of the above, the panel decided to allow the witness statement of Ms 7 into evidence as hearsay. What weight to be attached to it will be determined in the panel's consideration of all of the evidence at a later stage.

Background

The charges arose whilst Mrs Kelliher was employed as the Deputy Manager of Highgate Care Home (the Home). The Home is a residential home provides care to residents who have complex needs and a high care dependency.

On 22 January 2019, BUPA Quality Manager (Ms 1) and Regional Director (Ms 2) visited the Home to undertake a Monthly Home Review. During this visit, concerns about medication management and clinical governance were raised by Ms 1 and Ms 2. Following these concerns being raised, BUPA provided extra support to the Home. When BUPA began looking into concerns, it is alleged that previous concerns that were raised by external professionals and by Ms 3 were not reported to BUPA. If concerns

are raised by an external stakeholder, then these should be reported by the management of the Home to the Regional Director at BUPA.

Ms 1 and Ms 2 put plans in place to improve the Home's performance and to address the concerns, however, it is alleged that these plans were not implemented. An internal investigation was carried out by BUPA and Mrs Kelliher was referred to the NMC.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kennedy.

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

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

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

- Ms 1: Regional Quality Manager at BUPA.
- Ms 2: Regional Director at BUPA.
- Ms 3: Employed by the Whittington Health & Islington Council People Directorate Nurse Lead for Clinical Standards, Quality and Assurance.
- Ms 4: Head of Operation Quality at BUPA.
- Ms 5: Employed by Islington Council as a Trusted Assessor Nurse.

- Ms 6: Nurse Assessor at Continuing Healthcare.

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.

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

Charge 1

1. Did not ensure action plans were always
a) Reviewed
b) signed off.
c) followed up on.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 2 and Ms 7.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'As deputy manager, the Registrant was the clinical lead for the Home and was responsible for tasks such as audits, action plans, daily walk around, care plans and resident risk assessments.'*

The panel had sight of Ms 2s witness statement in which she stated the following:

> *'As deputy manager, the Registrant was the responsible Clinical Lead within the Home. This role involved ensuring that high quality good practice was delivered consistently and that satisfactory standards of care were maintained. The Registrant was also responsible for ensuring compliance with all regulatory and company quality requirements through audits, reviews and training. She had to*

ensure that trained nurses worked in accordance with company policies and the NMC code of conduct.'

The panel also had sight of Ms 7's witness statement in which she stated the following:

'I also reviewed care plan audits and medication audits to assess their accuracy. I found that action plans set following an audit were all not reviewed and signed off.'

The panel had sight of Ms 4's witness statement in which she stated the following:

''[Ms 1] and [Ms 2] put plans in place to improve the Home but reported that the Registrant and [Colleague A] were dismissive in relation to suggested improvements. Action plans were never carried out. I do not have specific details in this respect.

The Registrant denied that action points had been set for the Home in safeguarding meetings.'

The panel heard oral evidence from Ms 1, Ms 2 and Ms 4 in which they told the panel that Mrs Kelliher had a duty to ensure action plans were always reviewed, signed off and followed up on. This however had not happened. The panel found the evidence of Ms 1, Ms 2 and Ms 4 to be consistent, credible and reliable in respect of this charge. The panel therefore found this charge proved on the balance of probabilities.

Charge 2

2. Demonstrated poor engagement with external professionals.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 4 and Ms 6.

In her witness statement, Ms 4 stated the following:

> *"[Ms 1] and [Ms 2] put plans in place to improve the Home but reported that the Registrant and [Colleague A] were dismissive in relation to suggested improvements. Action plans were never carried out. I do not have specific details in this respect.*
>
> *The Registrant denied that action points had been set for the Home in safeguarding meetings.'*

The panel had sight of Ms 6's witness statement in which she stated the following:

> *'The Registrant and [Colleague A] did not positively respond to recommendations and requests made by me in relation to documentation and referrals. I made recommendations, such as the behaviour charts mentioned above, in an attempt to improve the quality and efficiently of their recording. These recommendations were not carried out.'*

The panel heard oral evidence from Ms 4 and Ms 6 who told the panel that Mrs Kelliher did not engage fully with external professionals. The panel found the evidence of Ms 4 and Ms 6 to be consistent, credible and reliable in respect of this charge. The panel determined that in being dismissive of concerns raised and suggested improvements, failing to ensure action plans were followed and carried out, Mrs Kelliher demonstrated poor engagement with external professionals. The panel therefore found this charge proved.

Charge 3.a)

3. Did not ensure care plans were:

a) In place for all residents

This charge is found not proved.

The panel concluded that an unknown number of residents did have care plans in place and therefore charge 3 a) is not proved.

Charge 3.b), 3.c) and 3.d)

3. Did not ensure care plans were:

b) Updated for residents when required
c) Regularly reviewed
d) Person Centred

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. The panel had particular regard to the evidence of Ms 1, Ms 6 and Ms 7.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *As deputy manager, the Registrant was the clinical lead for the Home and was responsible for tasks such as audits, action plans, daily walk around, care plans and resident risk assessments.*

The panel had sight of Ms 1's BUPA written witness statement form dated 12 May 2019 in which the following was stated:

> *'New Care plan documentation was not in place in all care plans and some of these were mixed with old care plans etc. the OM said that they had not had the care plan training but her name was identified along with a few others as havinq attended the training in the home.'*

The panel had sight of Ms 6's witness statement in which she stated the following:

'In addition, I found that entries that were actually present in patient notes were repeated for a number of patients, I do not remember the specifics of which patients and what entries. Entries were similar to the point that patients could not be identified from their notes other than the fact that their name was present. Given that the same entries were being recorded for multiple patients, I was concerned in relation to the accuracy of the entries. They did not contain any detail to suggest that they were patient specific and there was no evidence to suggest that entries were accurate.'

The panel also had sight of Ms 7's witness statement in which she stated the following:

'I found some concerns in relation to clinical oversight at the Home. Particularly, some of the care plans that I reviewed were not all personalised and were not all reflective of resident's needs. Some care plans were also not updated following visits from external professionals such as the Tissue Viability Nurse, their guidance on how to care for a wound was therefore not included in care plans…

… The care plans reviewed highlighted some concerns in relation to the completion of Resident of the Day documentation requirements and monthly review. This is a BUPA initiative where every resident is reviewed on a monthly basis. This involves reviewing their care plans and notes at a minimum monthly or as needs change, to ensure that their needs are met and any changes are catered for. I found that for some residents, this had not been reviewed and documentation did not always reflect their needs…

… I found that action plans set following an audit were all not reviewed and signed off.

The panel heard oral evidence from Ms 1 and Ms 6 who told the panel that Mrs Kelliher had a duty to ensure care plans were in place for all residents, that the care plans were updated when required, regularly reviewed and person centred. The panel found the evidence of Ms 1 and M6 to be consistent, credible and reliable in respect of this charge. The panel also noted the hearsay evidence of Ms 7 corroborated the other

evidence in respect of this charge. The care plans in place were not updated, reviewed and person centred as required. Accordingly, the panel found charges 3 b), c) and d) proved.

Charge 4

4. In relation to Patient V did not:
a) Ensure that their challenging behaviour was documented.
b) Ensure evidence of nursing need was recorded.
c) Take steps to ensure the appropriate information was recorded to support their funding

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 6.

The panel had sight of Ms 6's witness statement in which she stated the following:

> *'The Home had reported that [Patient V] had challenging behaviour and as a result, they were experiencing increased difficulty when administering care. The challenging behaviour was described as punching, kicking and swearing at staff when personal care was being administered. This meant that administering personal care to [Patient V] took longer than expected and that often, more than two carers were required to carry out personal care. The Home said that the challenging behaviour was happening daily. This had been verbally reported within the Home and to the relatives of [Patient V].*
>
> *Despite these issues, [Patient V's] challenging behaviour was not documented. I read through every note for [Patient V] going back to the date of admission into the Home, nothing was ever recorded in relation to challenging behaviour by the*

Home. At the time [Patient V] was fully funded. From [Patient V's] notes, there was no evidence of nursing need or any evidence that enhanced care was required. [Patient V] was therefore no longer eligible for funding based on this.

I had asked the Registrant to improve documentation and to complete behaviour charts for [Patient V] following an assessment I completed on 26 February 2018. [Patient V's] family disputed the information being documented in the patients' notes, I asked that this be improved so that the behaviour and the level of care required could be documented efficiently going forward. This was not done when I reviewed the documentation at later visits. As a result, I had no evidence that would allow me to recommend that full funding should continue. [Patient V] therefore had to restart the funding process again and be fully re-assessed.'

In her oral evidence Ms 6 told the panel that Mrs Kelliher had a responsibility to ensure that Patient V's challenging behaviour was documented, that evidence of nursing need was recorded, and steps taken to ensure the appropriate information was recorded to support their funding. This however did not happen. The panel found Ms 6's evidence to be consistent, credible and reliable. The panel therefore found that Mrs Kelliher did have a duty to ensure Patient V's challenging behaviour was documented, to ensure evidence of nursing need was recorded and to take steps to ensure that the appropriate information was recorded to support their funding. As this had not been implemented, the panel found this charge proved.

Charge 5

5. Did not ensure that where necessary, risk assessments were:
a) in place
b) complete
c) reviewed
d) been consistently followed by staff.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 2 and Ms 5.

The panel had sight of Ms 1's witness statement and Exhibit CQ 01, dated 22 January 2019 in which she stated the following:

> *'When a resident's weight changes, their moving and handling plans should be reviewed and adapted as needed, this was not being undertaken.*
> *One resident was on pureed food as a result of swallowing difficulty but no SALT (Speech and Language Therapist) consultation had been arranged.*
>
> - *No smoking risk assessment seen in safety plan*
> - *Bed rails no measurements, not counter signed*
> - *BI for lap belt and bed rails BI for lap belt is not fully completed…bed rails no measurements and no monthly r-v for Dec and Jan*
>
> *For residents with a high fall risk, there were no additional care plans in place to show how safety is managed. This is required for medium-high risk residents.'*

In her oral evidence, Ms 1 stated that despite having a duty to, Mrs Kelliher did not ensure that risk assessments were in place, complete, reviewed and consistently followed by staff.

The panel noted that Ms 5, in her witness statement, stated the following:

> *'I noticed that a few resident at the Home were in bed, with bed rails, but no bed bumpers were in place. The risk assessments for these residents stated that bumpers were in place. The Home therefore was not complying with their risk assessments and the residents were at risk of entrapment and injury.'*

'Bed rails and bumpers were now in place but risk assessments needed updating. Risk assessments need to be reviewed on a monthly basis and/or when there is a change. They were out of date.'

The panel also had sight of a contemporaneous record of concerns about risk assessments made by Ms 5 dated 1 March 2019. Ms 5 gave oral evidence and her evidence was consistent, credible and reliable.

Having regard to all of the above, the panel determined that Mrs Kelliher did have a duty to ensure that where necessary, risk assessments were in place, complete, reviewed and consistently followed by staff. This however did not happen. The panel therefore found this charge proved in its entirety.

Charge 6

6. Did not ensure 'Resident of the Day' reviews were taking place monthly for all residents.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 2 and Ms 7.

The panel had regard to the witness statement of Ms 1 in which she stated the following:

'This is a monthly review system for each resident in the Home, this is a clinical governance requirement within BUPA. I found that the Home was only carrying out one review per day in the whole Home, i.e. 30 or 31 reviews per month. As there were 52 residents at the time, some plans were not reviewed being reviewed on a monthly basis.

Monthly reviews should be carried out and should detail what has happened in that month e.g. any specialist visits (dietician, SALT), details of weight fluctuation, eating patterns etc. The purpose of this exercise is for staff to plan, review and evaluate care as per NMC standards (platform 3 assessing needs and planning care). In the Home, I often found that "no change this month" was being written instead of a comprehensive review being completed. Even if no change was true, simply stating this is not good practice as it is not a proper review of the month.

Management was emailed new policies and paperwork by BUPA. It was their job to communicate these changes and policies to staff, this was not being done. As a result in the lack of communication, new paperwork, My Portrait, key safety risks, resident of the day, and resident specific plans such as for seizures and falls were not in place, or inadequate.'

The panel had sight of an email from Ms 2 to Ms 4 dated 19 May 2019 in which the following was stated:

'Resident of the day not being carried out and overdue evaluations not being picked up the following day during HM / DHM walkabout when these should have been reviewed.'

The panel also heard oral evidence from Ms 1 and Ms 2 which was consistent with their written statements. The panel found the evidence of Ms 1 and Ms 2 to be credible and reliable in respect of this charge. The panel determined that Mrs Kelliher did have a responsibility to ensure that 'Resident of the Day' reviews were carried out for every resident each month. This however did not happen. The panel therefore found this charge proved. There was no counter argument made.

Charge 7

7. Did not ensure Daily Clinical Walk Rounds were:
a) carried out consistently
b) Were properly recorded on the relevant form.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 2.

The panel had sight of Ms 1's BUPAs written witness statement dated 12 May 2019 in which the following was stated:

> *'Daily clinical walk arounds and weekly clinical risk meetings were being done, but not consistenly done daily/weekly, these were also done per home and not per floor, actions were not always identified and evidenced as being signed off (if there were any).'*

The panel also had sight of Ms 2's witness statement in which she stated the following:

> *'Clinical Governance in relation to Clinical Risk- Daily Clinical Walk Round Forms, Weekly Clinical Risk meetings and the Monthly Compliance & Governance checklist for December was in the folder but not fully completed. For example, Daily Clinical Walk Round Forms must be completed daily but there were days when this had not been carried out, i.e. 29th and 301h December 2019.'*

The panel heard oral evidence from Ms 1 and Ms 2 who told the panel that Mrs Kelliher had a responsibility to ensure that daily clinical walk rounds were carried out consistently and were properly recorded on the relevant forms. This however did not happen. The panel found the evidence of Ms 1 and Ms 2 to be consistent, credible and reliable in respect of this charge. The panel therefore found this charge proved.

Charge 8

8. Did not ensure the ‘My Portrait’ tool for each resident was:
a) Complete or
b) Completed accurately

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 1.

The panel had sight of Ms 1’s witness statement in which she stated the following in respect of the ‘My Portrait’ tool::

> *‘I found that this information was missing altogether in some cases and was poorly completed with others. Information in relation to a resident's patterns and habits e.g. eating pattern and toilet pattern were not documented and kept up to date. This meant that for residents who could not communicate or did not have capacity, there was no way of telling if there was an issue as their regular patterns were not recorded…*
>
> *…The Key Safety Risk column on the forms I reviewed had blank sections, this is where risks such as weight loss, choking, acquiring infections, falling, having tracheostomy needing suctioning etc. should have been recorded. This was concerning given that these were complex residents.’*

In her oral evidence Ms 1 told the panel that Mrs Kelliher had a duty to ensure that the ‘My Portrait’ tool was complete and accurate for each resident. This however did not happen. The panel found Ms 1’s evidence to be consistent, credible and reliable in respect of this charge. The panel therefore found this charge proved.

Charge 9

9. Did not ensure medication protocols were consistently implemented adequately or at all.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 5.

The panel had sight of Ms 1's witness statement and noted the following:

'I found that the front sheets on MAR charts (which detail key risks such as allergies and choking risks as well as specifying how to administer certain medications) were different on each floor of the Home.

I found that TMARs (Topical Medication Administration Recording forms) were present in charts but the actual forms being used were out of date. The staff at the Home were unaware that these forms had been updated over a year ago. Some residents didn't have TMARs at all. The purpose of these records is to ensure clarity so that staff know what the topical medication is intended to treat, when and how often it should be given. A lot of this information was missing from TMARs such as the patient's name, DOB, name of cream, how often it was to be applied, what the cream was for and where it was to be applied. The registered nurses should have been reviewing and initialling these folders everyday. [Colleague A] and the deputy manager had a duty to oversee what was happening on the floor, by also spot checking these folders.'

The panel had sight of Ms 5's witness statement to the NMC in which she stated the following:

‘MAR charts were not fully completed and lacked key information such as allergies, GP information and identifying information such as residents' date of birth. This information was missing for a number of residents.

In addition, MAR charts were not properly completed by staff. There are codes on the bottom of the chart that staff can use to fill in the chart. Code C on a chart means "see more information overleaf". Staff at the Home were noting Code C on MAR charts but were then not providing further information overleaf. As a result, no explanation was being given as to what happened/what the issue was.

Prescriptions attached to charts were out of date. A copy of each resident's prescription should be attached to their MAR chart. This provides staff with key information such as the prescribed dose of medication and prescribed route. Prescriptions are renewed every month. Despite prescriptions being renewed, old prescriptions were attached to MAR charts.’

The panel also heard oral evidence from Ms 1 and Ms 5. The panel found the evidence of Ms 1 and Ms 5 to be consistent, credible and reliable in respect of this charge. As the Deputy Manager of the Home, the panel determined that it was Mrs Kelliher’s responsibility to ensure that medication protocols were implemented. Having regard to all of the above, the panel found that Mrs Kelliher did not ensure that medication protocols were adequate implemented, or in place at all. The panel therefore found this charge proved.

Charge 10.a)

10. Did not ensure medication:
a) Was securely stored when not in use

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 5.

In her witness statement, Ms 1 stated the following:

> *'On my walk round I found that treatment rooms containing medication were unlocked, these should be kept locked when no one is in there…* I found two bags of medication left unattended at a nurse station, which were therefore accessible by any resident who was passing.*'*

The panel had sight of Ms 5's notes from her visit on 1 March 2019 in which the following was stated:

> *'Noted that medication was not always booked in (Most of MAR-Charts) quantities and carried forward information was not clear.'*

The panel also had sight of the BUPA Medicines Management Policy dated 23 September 2019 in which the following was stated:

> *'Access to medication storage areas should be restricted to those with designated medication management responsibilities or people with the right to access these areas.'*

The panel heard oral evidence from Ms 1 and Ms5. The panel found the evidence of Ms 1 and Ms 5 to be consistent, credible and reliable. The panel determined that as the clinical lead, Mrs Kelliher had a duty to ensure that medication was securely stored when not in use. This however did not happen. The panel therefore found this charge proved.

Charge 10.b)

> 10. Did not ensure medication:
> b) Was disposed of properly when no longer required.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 3 and Ms 6.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'On a return visit, I found random medication in unlocked plastic drawers stored with various equipment and objects. When I asked a nurse [ ] why medications were being stored in this way the nurse said explained that management had told staff to store medication as Lloyds Pharmacy were poor in its delivery of medication to the Home, they therefore kept medications in these drawers in case they were needed. This had become standard practice. This was a very unsafe practice, all medication needs to be locked away or disposed of when not required. We are not allowed to use medication that has been prescribed to another resident for someone else.'*

The panel also had sight of Ms 6's witness statement in which she stated the following:

> *'In addition, Inadine, the medication that was being used on Patient CA was not documented on their medication chart and had not been prescribed.'*

The panel heard oral evidence from Ms 1, Ms 3 and Ms 6. The panel found the evidence of Ms 1, Ms 3 and Ms 6 to be consistent, credible and reliable in respect of this charge. The panel was of the view that as clinical lead, Mrs Kelliher had a responsibility to ensure that, when no longer required, medication was properly disposed of. Having regard to the above, the panel determined that Mrs Kelliher did not ensure medication was kept securely and disposed of properly when no longer required. The panel therefore found this charge proved.

Charge 10.c)

> 10. Did not ensure medication:
> c) Was properly recorded as received.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 5.

The panel had sight of Ms 5's witness statement in which she stated the following:

> *'We checked the medication charts of the residents in the Home. We found that medication was not always booked in once received and was therefore not properly recorded.'*

The panel also had sight of Ms 5's notes from her visit to the Home dated 1 March 2019, in which she recorded the following:

> *'Noted that medication was not always booked in (Most of MAR-Charts) quantities and carried forward information was not clear.'*

The panel also noted Exhibit CQ/01 from Ms 1 dated 22 January 2019, in which she recorded the following:

> *'On the first visit, it was the beginning of the new medicine cycle, and I noted that meds had not been signed in, there were no carried forward or brought forward balances and no stock balance amount seen.'*

The panel heard oral evidence from Ms 5 and Ms 1. The panel found the evidence to be consistent, credible and reliable in respect of this charge. The panel was satisfied that as clinical lead, Mrs Kelliher was responsible for ensuring medication was properly recorded as received. Having regard to the evidence as set out above, the panel determined that Mrs Kelliher did not ensure that medication was properly recorded as received. The panel therefore found this charge proved.

Charge 10.d)

10. Did not ensure medication:
d) Was labelled with opening dates.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 5.

The panel had sight of Ms 5's witness statement in which she stated the following:

'We found that medication boxes and bottles had been opened but the date of opening was not documented. The date of opening is supposed to be written on the bottle/box so that an expiry date can be ascertained.'

The panel had regard to the BUPA Medicines Management Policy dated 23 September 2019 in which the following was stated:

'Make sure that dates of opening are recorded on items as required (stickers provided by pharmacy).'

The panel heard oral evidence from Ms 5. The panel found the evidence of Ms 5 to be consistent, credible and reliable in respect of this charge. As set out previously, the panel was satisfied that Mrs Kelliher, as she was clinical lead, was responsible for ensuring that medication was labelled with opening dates. The panel determined that Mrs Kelliher did not ensure that medication was labelled with opening dates. Accordingly, the panel found this charge proved.

Charge 10.e)

10. Did not ensure medication:
e) Stock levels were monitored and/or recorded.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 5 and to the BUPA Medicines Management Policy dated 23 September 2019.

The panel noted the following as set out in the BUPA Medicines Management Policy:

> *'Clinician (Senior Carer in a residential home) ensures a weekly stock check is carried out of all prescribed medication including Controlled Drugs, PRN medication & self-administered medication.'*

The panel had regard to the evidence of Ms 1 in particular her note dated 22 January 2019 and also the witness statement of Ms 5 in which she stated the following:

> *'Stock levels of medication are required to be monitored and recorded. This was not being done accurately. For example, Resident [ ] was prescribed sodium bicarbonate. It was noted that on the 24/2/2019 at 17.30hrs the balance left of this medication was 32 capsules. The next morning on the 25/2/2019 the balance received was noted as 29 capsules. I do not recall the specifics of what happened but recall that this recording was not accurate.'*

The panel heard oral evidence from Ms 1 and Ms 5. The panel found the evidence to be consistent, credible and reliable in respect of this charge. The panel determined that Mrs Kelliher, as clinical lead, had a duty to ensure that medication stock levels were monitored and/or recorded. This however did not happen. The panel therefore found this charge proved.

Charge 10.f)

> 10. Did not ensure medication:
> f) Was delivered to the Home in time to avoid residents missing doses.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'I found that medication charts were not signed and therefore medication had not been given. This was the case even for complex residents, for example, a resident [ ] with cancer on palliative care who was also prescribed antipsychotics medication. Some of Resident [ ] medication had not been administered, I do not recall which medication. When I asked a nurse [ ] why this chart had not been updated, she stated that the medication had not arrived yet from pharmacy. I got the impression that this was a usual occurrence. I asked why it had not yet arrived and was told that it may arrive tomorrow with a very unconcerned attitude. The medication should have been urgently requested and should have been collected in person in this scenario. Incidents such as this were not reported on Datix as they should have been.'*

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

> *'SOVA was not being followed by the Registrant. One example is of a resident who missed their medication as it had not yet arrived from the pharmacy; this should have been investigated and raised as a safeguarding. This was not done, no safeguarding was raised. The missing of medication may have resulted in harm.'*

The panel heard oral evidence from Ms 1 and Ms 3. The panel found the evidence of Ms 1 and Ms 3 to be consistent, credible and reliable in respect of this charge. The panel determined that as clinical lead, Mrs Kelliher had a responsibility to ensure that medication was delivered to the Home in time to avoid residents missing doses. This however did not happen. The panel therefore found this charge proved.

Charge 10.g)

10. Did not ensure medication:
g) Was being administered according to the prescription

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 5.

The panel had sight of Ms 5's witness statement in which she stated the following:

'Prescriptions attached to charts were out of date. A copy of each resident's prescription should be attached to their MAR chart. This provides staff with key information such as the prescribed dose of medication and prescribed route. Prescriptions are renewed every month. Despite prescriptions being renewed, old prescriptions were attached to MAR charts.'

The panel also had sight of Ms 1's witness statement in which she stated the following:

'I found that medication charts were not signed and therefore medication had not been given. This was the case even for complex residents, for example, a resident [ ] with cancer on palliative care who was also prescribed antipsychotics medication. Some of Resident [ ] medication had not been administered, I do not recall which medication. When I asked a nurse [ ] why this chart had not been updated, she stated that the medication had not arrived yet from pharmacy. I got the impression that this was a usual occurrence. I asked why it had not yet arrived and was told that it may arrive tomorrow with a very unconcerned attitude. The medication should have been urgently requested and should have been collected in person in this scenario. Incidents such as this were not reported on Datix as they should have been.

In addition, morning medication, which needed to be administered on an empty stomach and therefore before breakfast, was found to have been signed for later on in the day, meaning that it was administered later in the day.

There were also administering errors; one resident was supposed to take Leviteracetum (antiepileptic medication) twice a day but was only given it once a day. Not having the correct level of medication could result in a seizure. Another resident was prescribed Diazepam for seizures, the Home had recorded this as anticipatory medication. Diazepam was not prescribed as anticipatory medication, it was required in the event of a seizure and therefore this resident's protocol was incorrectly recorded. If the resident has a seizure, Diazepam must be administered, the risk if not administered is an extended seizure which can lead to a lack of oxygen, brain damage and even death.'

The panel heard oral evidence from Ms 1 and Ms 5. The panel found the evidence of Ms 1 and Ms 5 to be consistent, credible and reliable in respect of this charge. The panel determined that Mrs Kelliher, as clinical lead, had a duty to ensure that medication was being administered in accordance with the prescription. This however did not happen. Accordingly, the panel found this charge proved.

Charge 11

11. Did not adequately assess staff competency in relation to medication administration/practice.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 3 and Ms 4.

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

‘The Registrant was the clinical lead for the Home and was therefore responsible for medication management, care and staff competency…

…I found that many of the nurses at the Home lacked skill, there appeared to be one or two good nurses who were holding the Home together.’

The panel also had sight of Ms 1’s witness statement in which the following was stated:

There was also competency issues with staff. Some staff members were found to be incompetent in relation to administering medication. I found out that the deputy manager had passed a nurse [ ] as competent to administer who clearly was not. We looked into the nurses' personal file and could see that there were several instances where medication errors had taken place but when medication competencies were completed by the deputy manager, the nurse had passed. I conducted a medication competency with this nurse and she was clearly not safe and did not pass. I recall that she was unable to accurately measure fluids, did not know the correct process to give medication via a PEG and also had trouble understanding which medications needed to be given (she missed a few and I had to point this out).’

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

‘Staff members had raised concerns to the Registrant about the medication practices of some nurses at the Home, in particular, issues surrounding PEG tubes. I received statements from two members of staff, exhibited [ ].

Staff had written letters to the Registrant expressing these concerns however these letters were never found whilst investigating and these concerns were not reported on the appropriate systems.

The Registrant admitted that she was aware of the concerns of staff at the Home and had similar concerns herself in relation to staff competency. Despite this, she had not done anything about them.

Whilst the Registrant had concerns in relation to one nurse, she passed that nurse as competent to prescribe and administer medication. I do not recall the name of this nurse. This particular night nurse failed a medication competency in February 2019 and had last been assessed in 2017. Competency should be assessed annually.'

The panel heard oral evidence from Ms 1, Ms 3 and Ms 4. The panel found the evidence of Ms 1, Ms 3 and Ms 4 to be consistent, credible and reliable in respect of this charge. The panel determined that as clinical lead Mrs Kelliher had a duty to adequately assess staff competency in relation to medication administration. This however did not happen. The panel therefore found this charge proved.

Charge 12.a)

12. Did not take steps to ensure the security and safety of the Residents in that:
a) Treatment rooms were not locked when not in use.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 2.

The panel had sight of Ms 1's witness statement in which she stated the following:

'On my walk round I found that treatment rooms containing medication were unlocked, these should be kept locked when no one is in there.'

Ms 1 also recorded this in her notes dated 22 January 2019.

The panel also had sight of Ms 2's witness statement in which she stated the following:

'The clinical treatment rooms should also be locked, these were unlocked and wide open.'

The panel heard oral evidence from Ms 1 and Ms 2 who confirmed that Mrs Kelliher had a duty to ensure the security and/or safety of the residents. It also heard from these witnesses that they found treatment rooms unlocked when they were not in use. The panel found the evidence of Ms 1 and Ms 2 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 12.b)

12. Did not take steps to ensure the security and safety of the Residents in that:
b) Sluice rooms were not locked when not in use.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1.

The panel had sight of Ms 1's witness statement in which she stated the following:

'The sluice rooms at the Home should always be locked, these were unlocked and wide open.'

The panel also had sight of Ms 2's witness statement and noted the following:

'Sluice rooms were also open, this is where dirty laundry is stored, bed pans are washed and where waste is disposed. Sluice rooms are considered dirty should not be easily accessible to avoid cross-infection.'

The panel heard oral evidence from Ms 1 and Ms 2 who confirmed that Mrs Kelliher had a duty to ensure the security and/or safety of the residents. It also heard from these witnesses that they found sluice rooms unlocked. The panel found the evidence of Ms 1

and Ms 2 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 12.c)

> 12. Did not take steps to ensure the security and safety of the Residents in that:
> c) Fire exits were not clear.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 2.

The panel had sight of Ms 1's witness statement in which she stated that there *'was also items in front of fire exit'* in her walk round at the Home.

The panel also had sight of Ms 2's witness statement in which she stated that *'Fire exits were blocked and propped open.'*

The panel heard oral evidence from Ms 1 and Ms 2 who confirmed that Mrs Kelliher had a duty to ensure the security and/or safety of the residents. It also heard from these witnesses that they found that fire exits were not clear. The panel found the evidence of Ms 1 and Ms 2 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 12.d)

> 12. Did not take steps to ensure the security and safety of the Residents in that:
> d) Waste management sheets were not in place.

This charge is found proved.

In reaching this decision, the panel took into account al of the evidence before it. It had particular regard to the evidence of Ms 1.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'There were no waste management sheets in place contrary to BUPA policy and NICE guidelines.'*

The panel also heard oral evidence from Ms 1 in which she stated that it was Mrs Kelliher's responsibility to ensure the security/and or safety of the residents. She also stated that waste management sheets were not in place at the Home. The panel found Ms 1's evidence to be consistent, credible and reliable in respect of this charge. The panel therefore found that Mrs Kelliher did not take steps to ensure the security and/or safety of the residents in that she did not ensure that waste management sheets were in place. Accordingly, the panel found this charge proved.

Charge 12.e)

> 12. Did not take steps to ensure the security and safety of the Residents in that:
> e) There were no working pagers in the Home.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 5.

The panel had sight of Ms 2's witness statement in which she stated the following:

> *'Pagers and Call Bell System- Staff are supposed to carry pagers on them during their shift. Residents can ring a call bell when in need and staff are notified through the pager. I found that there were no working pagers in the Home. I had offered more pagers to all the homes under my supervision. The Registrant said that it would be nice to have them as the Home had none that were working.*

They had 25 previously but these had all gone missing and were never replaced. The fact that this system was not in place meant that residents did not have a mechanism to call staff when needed, which raises concerns as to the safety of residents. I do not recall exactly when this came to my attention.'

The panel also had sight of an email from Ms 5 sent to Ms 4 on 19 May 2019 in which she stated the following:

'Pagers for the call-bell system The home had no working pagers in the home. This was identified when I informed all of my Home Manager's there was a small supply of pagers available if any homes needed additional handsets. [Colleague A] responded that it would be nice to have pagers. The home had been running for a long time with none. [Colleague A] confirmed they used to have them in the home. The maintenance operative confirmed they used to have around 25 in the home but these had gone missing over a period of time and had never been replaced.'

In her oral evidence, Ms 5 told the panel that Mrs Kelliher had a duty to ensure the security and/or safety of the residents. It also heard from Ms 5 that she found that there were no working pagers in the Home. The panel found the evidence of Ms 5 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 12.f)

12. Did not take steps to ensure the security and safety of the Residents in that:
f) You did not ensure incidents were being recorded on DATIX

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 4 and Ms 7.

The panel had sight of the witness statement of Ms 1 in which she stated the following:

> *'In particular, I found that there was a lack of understanding by staff of the Datix system. During my previous visit, I had specifically told staff to report appropriate issues on Datix, this was still not being done. I do not recall specific examples but I knew that that Datix was not being completed as I would pick up on medication issues and could see that they had not been recorded…*
>
> *… The Registrant was not very proficient with technology. She did not seek help in relation to this and simply did not carry out online tasks that she found difficult. An example of this is Datix, the Registrant's understanding of the system was not great. I supported and showed her how to report on Datix, she clearly did not find this easy.'*

The panel had sight of Ms 4's witness statement in which she stated the following:

> *'According to Datix, there was not a single medication incident in the Home between 2017 and 2018. Given the various reports I received during the internal investigation, this seems very unlikely. The MHR, completed 22nd January 2019 by [Ms 2] and [Ms 1], identified that since December 2018 there had only been 1 incident reported since December 7th 2018. It also noted that no medication incidents were reported in 2018 despite in medication audits gaps noted on meds charts was a consistent theme. Gaps on medication charts should be recorded as an incident. Thus it is much more likely that these incidents were not reported.*
>
> *From what was reported to me, my findings were that staff were not using the paper reporting forms, they were verbally reporting to the [Colleague A] and deputy manager instead. This was a cause for concern as often a few shifts may have lapsed before the staff member saw the Registrants to report the issue. It also meant there was no paper trail.'*

The panel also had sight of Ms 7's personal notes that she completed after visiting the Home in which she has recorded the following:

'Staff don't complete DATIX forms – staff currently tell [Colleague A] and she completes.'

The panel heard oral evidence from Ms 1 and Ms 4. In their evidence they told the panel that it was Mrs Kelliher's responsibility to ensure that the DATIX system was being used. This however did not happen. The panel found the evidence of Ms 1 and Ms 4 to be consistent, credible and reliable. It also found that Ms 7's evidence corroborated the evidence of Ms 1 and Ms 4. The panel found that Mrs Kelliher was responsible for ensuring that the DATIX system was being used properly and that this was not the case. The panel therefore found this charge proved.

Charge 12.g)

12. Did not take steps to ensure the security and safety of the Residents in that:
g) Oxygen cylinders were being stored in clinical rooms and not outside.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 5.

The panel had sight of the witness statement of Ms 5 in which she stated the following:

'Oxygen cylinders were being stored in clinical rooms. These should not be kept inside if they are not in use as they are a fire hazard. I escalated this concern to BUPA and had no further involvement with this.'

The panel also had sight of Ms 5's notes from her visit to the Home dated 1 March 2019 in which the following was stated:

'It was identified that on the clinical room were stored the Oxygen cylinders – unsure of what the policy is, as it is normally advised to keep this equipment outside unless in use.'

The panel heard oral evidence from Ms 5 who said that Mrs Kelliher had a duty to ensure the security and/or safety of the residents. It also heard from Ms 5 that they found that oxygen cylinders were being stored in clinical rooms. The panel found the evidence of Ms 5 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 13.a) and 13)b.

> 13. Did not ensure that
> a) Up-to-date Topical Medication Administration Records ("TMAR") forms were being used.
> b) TMARs were being completed or correctly completed by the nursing staff.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 1 and the BUPA Medicines Management Policy dated 23 September 2019.

The panel had sight of the BUPA Medicines Management Policy dated 23 September 2019 in which the following was stated:

> *'It is important that the administration of topical medicines (e.g. creams and ointments) is always recorded. A My Topical Medication and Recording Form must be in place to record application of topical medicines, these need to be referred to on the MAR.'*

The panel had regard to the witness statement of Ms 1 in which the following was stated:

> *'I found that TMARs (Topical Medication Administration Recording forms) were present in charts but the actual forms being used were out of date. The staff at*

the Home were unaware that these forms had been updated over a year ago. Some residents didn't have TMARs at all. The purpose of these records is to ensure clarity so that staff know what the topical medication is intended to treat, when and how often it should be given. A lot of this information was missing from TMARs such as the patient's name, DOB, name of cream, how often it was to be applied, what the cream was for and where it was to be applied. The registered nurses should have been reviewing and initialling these folders every day. The Registrant and Home manager had a duty to oversee what was happening on the floor, by also spot checking these folders…

The panel noted Ms 1's evidence which it found to be consistent, credible and reliable in respect of this charge. The panel was satisfied that Ms Kelliher had a duty to ensure that up to date TMAR forms were being used and completed correctly by nursing staff having had sight of the BUPA Medicines Management Policy dated 23 September 2019. The panel therefore found this charge proved.

Charge 13.c) and 13.d)

13. Did not ensure that
c) The MAR charts front sheets were the same on each floor of the Home
d) Medication charts were
    i. being signed
    ii. completed fully and/or properly

This charge is found proved.

In reaching this decision the panel had regard to all of the evidence before it. It had particular regard to the evidence of Ms 1.

In her witness statement Ms 1 stated the following:

‘MAR charts were not fully completed and lacked key information such as allergies, GP information and identifying information such as residents' date of birth. This information was missing for a number of residents.

In addition, MAR charts were not properly completed by staff. There are codes on the bottom of the chart that staff can use to fill in the chart. Code C on a chart means "see more information overleaf". Staff at the Home were noting Code C on MAR charts but were then not providing further information overleaf. As a result, no explanation was being given as to what happened/what the issue was.’

Ms 7 in her witness statement stated:

‘some medication charts were not signed and did not contain details such as allergies. Some up to date prescriptions were also not available.’

Ms 1 in her witness statement stated:

‘I found that medication charts were not signed and therefore medication had not been given.’

The panel had sight of Ms 1’s notes dated 22 January 2019 and her witness statement and oral evidence. The panel found the evidence of Ms 1 to be consistent, credible and reliable in respect of this charge. The panel therefore found this charge proved in its entirety.

Charge 14

14. Did not take immediate action to replace Resident A’s broken humidifier

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1 and Ms 4.

The panel had sight of Ms 1's witness statement in which she stated the following:

> *'There were instances where the Registrant was very slow acting in relation to issues that required immediate action. A resident's humidifier had broken and needed replacing, the humidifier was a vital part of the resident's care as a result of a tracheotomy (her throat had to remain moist). This was broken for three weeks before it was replaced. The Regional Director and I purchased a new humidifier but resident was without this for around three weeks.'*

The panel also had oral evidence from Ms 1 who stated that it was Mrs Kelliher's responsibility to replace Resident A's humidifier and she did not. The panel found Ms 1's evidence to be consistent, reliable and credible in respect of this charge. The panel was satisfied that it was Mrs Kelliher's responsibility to ensure that Resident A's broken humidifier was replaced immediately. This however did not happen. Accordingly, the panel found this charge proved.

Charge 15

> 15. Did not effectively
> a) Communicate new policies and/or paperwork produced by BUPA to the relevant staff.
> b) Implement procedure and policy.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 1, Ms 3, Ms 4 and Ms 7.

The panel accepted Ms 1's evidence in respect of this and determined that as the Deputy Home Manager, along with Colleague A, had a duty to ensure that policies and procedures were communicated and/or distributed to staff.

The panel also noted the following contained in Ms 1's witness statement:

> *'In addition, nurses did not have access to emails in the workplace which meant that they were unable to keep up to date with policy and paperwork themselves. They would have had to rely on verbal feedback from [Colleague A] and deputy manager but they were clearly not up to date themselves. This was easily resolved by myself and the Administrator in early 2019 and should have been done by [Colleague A] or deputy manager…*
>
> *.. Management was emailed new policies and paperwork by BUPA. It was their job to communicate these changes and policies to staff, this was not being done. As a result in the lack of communication, new paperwork, My Portrait, key safety risks, resident of the day, and resident specific plans such as for seizures and falls were not in place, or inadequate.*
>
> *…In this situation, I feel it would be unfair to blame the staff at the Home for the daily failings…'*

The panel had sight of Ms 4's handwritten notes dated 13 March 2019 in which she stated that policy and procedure was not being implemented by Mrs Kelliher.

The panel had sight of Ms 1's witness statement for the internal investigation dated 12 May 2019. The panel also heard oral evidence from Ms 1. The panel found Ms 1 and Ms 4's evidence to be consistent, credible and reliable in respect of this charge. It heard evidence from Ms 3 and the written evidence of Ms 7 that corroborated Ms 1's evidence. Having regard to all of the above, the panel found that Mrs Kelliher did not effectively communicate new policies and/or paperwork produced by BUPA to relevant staff and did not implement procedure and policy. Accordingly, the panel found this charge proved.

Charge 16

16. Did not ensure thickener was being used appropriately in the Home.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 3 and Ms 5.

The panel had sight of Ms 5's witness statement in which she stated the following:

> *'There were multiple issues relating to the use of thickener in the Home. Thickener, if not used correctly and when prescribed can lead to a risk of chocking or aspiration. No actual harm was caused, that I am aware, in the following situations but a potential risk of harm did exist.'*

The panel noted that in her witness statement, Ms 5 set out a number of examples where thickener was not appropriately used at the Home.

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

> *'Staff were found to be using thickened fluid that belonged to a deceased resident for other residents when each resident requires their own prescription and supply. One staff member did not know that this was against procedure and another did not understand how to use thickened fluid.'*

In their oral evidence, Ms 3 and Ms 5 told the panel that it was Mrs Kelliher's responsibility to ensure that thickener was being used appropriately. This however did not happen. The panel found the evidence of Ms 3 and Ms 5 to be consistent, credible and reliable. The panel therefore found this charge proved.

Charge 17

17. Did not ensure food and fluid changes were being regularly and/or accurately updated.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 1 and Ms 2.

The panel had sight of Ms 1's witness statement in which the following was stated:

'Food and fluid charts were generally hit and miss in terms of being regularly and accurately being updated. The Home seemed to be giving everyone fortified food when not everyone needed it. There is a risk of weight gain if residents are given fortified when they do not need it. It should only be given to residents who are at risk of losing weight.'

In her witness statement, Ms 2 stated the following:

'Resident was still receiving variable doses of thickener. This had not been rectified as per our recommendation. I did not witness an incorrect dose being administered but noticed that this had not been rectified as variable doses were still being recorded in Resident notes.'

The panel heard oral evidence from Ms 1 and Ms 2. The panel found the evidence of Ms 1 and Ms 2 to be consistent, credible and reliable in respect of this charge. The panel therefore found that it was more likely than not that Mrs Kelliher was responsible for ensuring that food and fluid charts were being regularly and/or accurately updated. Accordingly, the panel found this charge proved.

Charge 18

18. Did not ensure updated Speech and Language Therapy (“SALT”) descriptors were being used.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 5.

The panel had sight of the witness statement of Ms 5 in which she stated the following:

‘There were issues in relation to Speech and Language Therapy ("SALT") documentation. SALT descriptors, which provide resident specific instructions in relation to food and fluid consistencies to promote safe swallowing had been updated by the SALT team. Despite this, a poster of the old descriptors was still on display and both new and old descriptors were found mixed in a folder. This was causing confusion as to what was up to date and was placing residents at risk…

… [Ms 3] and I returned to the Home on 6th March 2019. 39. This visit focused on reviewing all of the SALT forms for residents in the Home. We found that there was still a mix of new and old descriptors in use despite us asking that these be updated.’

The panel heard oral evidence from Ms 5. The panel found Ms 5’s evidence to be consistent, credible and reliable. The panel therefore found that Mrs Kelliher did have responsibility to ensure that updated Speech and Language Therapy (“SALT”) descriptors were being used consistently. This however did not happen. Accordingly, the panel found this charge proved.

Charge 19

19. Did not ensure that the information being provided to the kitchen for food preparation matched the risk matrix in relation to SALT.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 5.

The panel had sight of Ms 5's witness statement in which she stated the following:

'In addition, we found that the information being given to the kitchen did not match the risk matrix in relation to SALT. Information provided to the kitchen in relation to dietary requirements and food consistency for residents did not match the information recorded on the risk matrix.'

The panel heard oral evidence from Ms 5. The panel found Ms 5's evidence to be consistent, credible and reliable. The panel therefore found that Mrs Kelliher did have a responsibility to ensure that the information being provided to the kitchen for food preparation matched the risk matrix in relation to SALT. This however did not happen. Accordingly, the panel found this charge proved.

Charge 20.a) and 20.b)

20. With regards resident's wounds, did not ensure
a) Plans were put in place following visits from the Tissue Viability Nurse.
b) Care was properly documented.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1.

In her witness statement, Ms 1 stated the following:

> *'Wound plans were often not put in place following visits from the Tissue Viability Nurse. Where wound plans were in place, there was no mention of how wounds were healing and no mention of frequency of dressing. Wound evaluations were not kept up to date and photos taken were unclear. Reports were not set out as per procedure (one wound per page when being detailed), the pictures were just thrown in the folder and not mounted. This is important as safeguarding can be raised around poor wound care. A lack of detail in a care plans could lead to a deterioration of the wound, pain for the resident and possible infection. If there is no record of how the wound is healing, then monitoring improvement/deterioration is difficult. As the clinical lead, the Registrant should have been picking up all of these issues to ensure that residents were being managed safely.'*

The panel heard oral evidence from Ms 1. The panel found her evidence to be consistent, credible and reliable in respect of this charge. The panel was satisfied that as clinical lead, Mrs Kelliher had a duty to ensure that plans were put in place following visits from the Tissue Viability Nurse and that care was properly documented. The panel found that Mrs Kelliher did not ensure that plans were put in place following visits from the Tissue Viability Nurse and that care was properly documented. The panel therefore found this charge proved.

Charge 20.c)

> 20. With regards resident's wounds, did not ensure
> c) Safeguarding concerns were raised.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it. The panel found that there was no evidence that Safeguarding concerns were not raised

about the resident's wounds. The panel therefore determined that the NMC had failed to discharge its evidential burden in respect of this charge. Accordingly, the panel found this charge not proved.

Charge 21

21. In relation to Patient C

a) A wound which had been present since 2013 was being dressed with Inadine which is inappropriate for long term use.

b) The use of Inadine:

i. was not documented on their medication chart

ii. Had not been prescribed

c) In the wound assessment chart there was

i. No documented evidence

ii. No measurement of the wound

d) No wound management care plan in place

e) No photographic evidence of the wound in the patient's notes

f) No evidence of the wound being reviewed by a relevant professional

g) No evidence that a referral to a Tissue Viability Nurse had been made.

h. Did not make a timely referral to Speech and Language when he reported coughing when eating.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 4 and Ms 6.

The panel had sight of Ms 6's witness statement in which she stated the following:

> *'Upon assessing, I became aware that [Patient C] was receiving treatment at the Home for a wound that had been present since 2013.*
>
> *The nurses at the Home were dressing the wound with whatever they wanted. They were using Inadine and Tegaderm Foam Adhesive Dressing to treat the wound. Inadine is not something that can be used long term. There was no documented evidence in the wound assessment chart and no measurement of the wound. There was no wound management care plan in place to treat the wound, no photographic evidence of the wound in the patient's notes and no evidence of the wound having ever been reviewed by a GP, Dermatology or a Tissue Viability Nurse. A Tissue Viability Nurse referral had not been made and therefore the Home had not received any guidance on how to treat the wound. I advised that the Home should request a review by his GP, Tissue Viability Nurse and query a dermatology referral regarding care and management of the wound.*
>
> *Upon finding the wound, a referral should have been made to a Tissue Viability Nurse for guidance on the correct course of treatment. This was not done.*
>
> *In addition, Inadine, the medication that was being used on was not documented on their medication chart and had not been prescribed.*
>
> *[Patient C] had also made the Home aware that he had begun coughing when eating. Nothing was done about this. This change should have been documented and a referral to Speech and Language should have been made to assess whether treatment or diet needed adjusting. There was a risk of choking as the Patient ate by himself.'*

The panel also had sight of Ms 4's witness statement in which she stated the following:

> *'An example of this was a concern raised by the Tissue Viability Nurse in relation to wound management in the Home. The Continuing Healthcare (CHC) nurse reported on February 28th 2019 a safeguarding concern as she visited a resident who had a sarcoma wound on his leg which was being dressed with inadine. There was no care plan in place, dressing changes not being recorded and no wound measurements. This was not logged on Datix. I cannot find any further information regarding this resident.'*

The panel heard oral evidence from Ms 4 and Ms 6 who stated that Mrs Kelliher was responsible for ensuring the correct wound care was provided to Patient C and it was also her responsibility to ensure a timely referral was made to SALT when he reported coughing when he was eating. This however did not happen. Having regard to all of the above the panel found this charge proved in its entirety.

Charge 22

> 22. In relation to Patient W did not respond adequately to concerns raised by Nurse A and Patient W's niece that Patient W was scared of a male night nurse on 10 April 2018 in that
> a) No reassurance was given that you would look into the issue.
> b) Did nothing to investigate the concerns raised.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 6.

The panel had sight of Ms 6's witness statement in which she stated the following:

‘One major concern that I did have in relation to a staff member at the Home, and also the way in which the matter was dealt with, was in relation to [Patient W] I am not willing to disclose the name of this patient due to data protection.

I saw [Patient W] on 10th April 2018. [Patient W] had dementia. Her niece had become concerned about the fact that [Patient W] was scared of a male night nurse, I do not recall his name. [Patient W] niece thought that this nurse may have been doing "something" to her aunt as she was scared every time the staff member came near. The specifics of what "something" was being done was never discussed with me. The niece was also concerned that [Patient W’s] notes were also very poorly documented.
I asked [Patient W’s] niece if she was happy for me to report her concerns to management at the Home immediately. The niece was reluctant to report as "concerns were not taken seriously" at the Home.

I reported these concerns to the [Colleague A] and deputy manager, along with [Patient W’s] niece, that day.

The response by the [Colleague A] and deputy manager was not adequate. No reassurance was given to myself or the niece that they would look into the issue and ultimately nothing was done to investigate.

I found out that the niece had previously requested female carers, back in February 2016 when [Patient W] was admitted to Home, but this had not been done.

[Colleague A] and deputy manager said that [Patient W’s] care plan would be changed to reflect this request.

I do not know whether a female nurse was assigned to the patient after this as her funding came to an end in May 2018 so I had no further dealings.

The panel also heard oral evidence from Ms 6. The panel found that Ms 6's evidence in respect of this charge was consistent, credible and reliable. The panel was satisfied that Mrs Kelliher had a responsibility to respond adequately to concerns raised by Nurse A and Patient W's niece by investigating the issue and providing reassurance to the resident and their niece that matters would be resolved. This however did not happen. The panel found that there is a risk of abuse in a setting where patients are unable to speak up and express themselves. This was of particular concern in the Home given that it housed the most complex patients, of which around 95% did not have capacity. The panel therefore found this charge proved in its entirety.

Charge 23

23. Did not ensure confidential information was
a) Kept in cabinets which were locked
b) not left unattended

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2.

The panel noted the following in Ms 2's witness statement:

'…Cabinets designated to house confidential information were unlocked and I found that a variety of confidential paperwork had been left out at the nurse's stations and in the communal lounges with was a GDPR issue.

Issues in relation to personal documentation been left unattended in the Home had not been rectified and therefore was still a GDPR breach. Medication treatment rooms, sluices and confidential cupboards were still unlocked and open.'

The panel also heard oral evidence from Ms 2 who told the panel that Mrs Kelliher was responsible for ensuring that the Home was compliant with data protection law/regulations.

The panel found the evidence of Ms 2 to be consistent, credible and reliable. It found that Mrs Kelliher had a responsibility to ensure that the Home complied with data protection law/Regulations. This however did not happen. The panel therefore found this charge proved.

Charge 24.a)

> 24. Did not ensure staff:
> a) Took their breaks in designated staff areas.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 2.

In her witness statement, Ms 2 stated the following:

> *'Staff were frequently using their phones whilst on duty and were taking breaks in communal areas as opposed to designated staff areas.'*

The panel also had sight of an email from Ms 2 to Ms 4 dated 19 May 2019 in which she stated that staff were taking their breaks in communal areas rather than designated staff areas.

The panel heard oral evidence from Ms 2 who told the panel that it was Mrs Kelliher's responsibility to ensure that staff took their breaks in designated staff areas. However, the panel had no evidence that designated staff areas existed within the building. Accordingly, the panel found this charge not proved.

Charge 24.b)

24. Did not ensure staff:
b) Did not use their personal phones whilst on duty.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it.

The panel had sight of Ms 2's witness statement in which the following was stated:

'Staff were frequently using their phones whilst on duty and were taking breaks in communal areas as opposed to designated staff areas.'

The panel had no other evidence or information about any policy in respect of staff usage of mobile phones in the Home. The panel heard evidence that the pager system was not working, and it was therefore possible that staff were using mobile phones to communicate with each other. The panel was of the view that the NMC had not discharged its evidential burden and found this charge not proved.

Charge 25

25. Did not ensure the DOLS tracker was up to date and/or accurate.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, having particular regard to the evidence of Ms 1 and Ms 4.

The panel had sight of Ms 1's witness statement in which she stated the following:

'...the DOLS tracker in the Home was not up to date and accurate. It was not clear which residents were funded and by which authority. Some DOLS referrals

had been sent to the wrong DOLS team. There were 17 safeguarding concerns raised in relation to DOLS from the initial inspection in January 2019...'

The panel also had sight of Ms 4's witness statement in which she stated the following:

'DOLS- BUPA's "Consent, Mental Capacity Act (MCA) 2005, Best Interest (BI) Decision Making and Deprivation of Liberty Safeguard (DOLS) Policy" is exhibited at SH/09.

a. DOLS are separate to the Datix system and therefore are not logged on this system. b. DOLS are managed by the Home and the respective DOLS authority. The Home deals with various DOLS authorities, these will differ depending on the residents referring authority.
c. For DOLS to apply, a resident must meet the DOLS specific criteria and the Home must make an application. There were a high number of residents who met the criteria in the Home.
d. It became apparant in the internal investigation that the Registrant was not following the correct DOLS procedure. She was sending all DOLS through to Islington via post, this was not always the correct place to be sending them as the Home was dealing with multiple DOLS authorities. When DOLS were not acknowledged or put in place due to them having been sent to the wrong location, the Registrant was not following up. The Registrant did not seem to understand that there were various DOLS authorities.
e. In addition, paper applications were still being completed as opposed to using the streamlined online process.
f. DOLS should appear on the Home's tracker, but the tracker was not being completed.'

The panel heard oral evidence from Ms 1 and Ms 4 who said that Mrs Kelliher had a duty to ensure that the DOLS tracker was up-to date and accurate. This however did not happen. The panel found the evidence of Ms 1 and Ms 4 to be consistent, credible and reliable in respect of this charge. Accordingly, the panel found this charge proved.

Charge 26

26. Did not ensure the forms for capacity and/or best interest decisions were being completed correctly in that they
a) Were not person centred
b) Did not specify the Key Decision that had been made
c) Lacked detailed reasoning as to why a decision was in the resident's best interests.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 1, Ms 3 and Ms 7.

The panel had sight of Ms 1's witness statement in which she stated the following:

'Completing mental capacity assessments and making best interest decisions for those who do not have capacity is a legal requirement under the Mental Health Act 2005. Within the Home, the forms for capacity and best interest decisions were not being filled in correctly; they were not person centred and not specific as to the Key Decision that had been made. Forms also lacked detail to evidence why this decision was made in the resident's Best interest. In addition, the DOLS tracker in the Home was not up to date and accurate. It was not clear which residents were funded and by which authority. Some DOLS referrals had been sent to the wrong DOLS team. There were 17 safeguarding concerns raised in relation to DOLS from the initial inspection in January 2019.'

The panel noted Ms 3's witness statement, in particular, the following:

'I informed BUPA of some of the concerns that [Ms 5] had reported, particularly concerns in relation to staff understanding and competency…

… c. It was also unclear whether capacity assessments were in place for some residents.'

The panel had regard to Ms 7's witness statement in which she stated the following:

'In relation to documentation, the Home was migrating care plans from one document to another, some residents had not yet been migrated but this was an ongoing process. Documentation relating to mental capacity was also not always compliant, it was not always clear how residents were supported to make their own decisions and personal preferences recorded.'

The panel also had sight of the BUPA Consent, Mental Capacity Act (MCA) 2005, Best Interest (BI) Decision Making and Depravation of Liberty Safeguards (DoLS) Policy dated 23 January 2019.

The panel also heard oral evidence from Ms 1 and Ms 3. It found their evidence to be consistent, credible and reliable in respect of this charge. The panel also found that the evidence of Ms 1 and Ms 3 was corroborated by the witness statement of Ms 7. Having regard to all of the evidence, the panel was satisfied that Mrs Kelliher had a duty to ensure that the forms for capacity and best interest met the requirements of the Mental Capacity Act 2005 and were being complied with. The panel found that the forms for capacity and/or best interest decisions were not filled in correctly, in that they were not person centred, did not specify the key decision that had been made and they lacked detailed reasoning as to why a decision was in the best interests. Accordingly, the panel found this charge proved.

Charge 27

27. Did not take steps to promote communal activities for the residents.

This charge is found not proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2.

The panel had sight of Ms 2's witness statement in which she stated the following:

> *'Activities and Communal Areas- I became concerned at the number of residents that were staying in their rooms 24/7. Residents used to come out of their rooms but this had stopped for most with no plausible reason. Activities such as the Music Man had also stopped, this is a visiting entertainer who used to hold small group activities. BUPA restarted this enabling 25 out of 43 residents to come out of their rooms. No one could say why the residents were being kept inside their bedrooms and not encouraged to come out of their rooms. I identified this issue in the February.'*

The panel also had sight of an email from Ms 2 to Ms 4 dated 19 May 2019 in which she stated the following:

> *'Residents staying in their rooms that used to come out of the room and very limited stimulation or social inclusion for residents in their rooms.'*

The panel heard oral evidence from Ms 2 who said that it was Mrs Kelliher's responsibility to promote communal activities for the Residents. The panel however found that whilst communal activities were lacking, the NMC had not discharged its burden to prove that Mrs Kelliher had not taken steps to promote such activities. The panel therefore found this charge not proved.

Charge 28

> 28. In relation to safeguarding:
> a) You did not consistently use the safeguarding tracker
> b) Did not consistently report concerns/incidents.
> c) Did not follow the appropriate processes.
> d) Did not complete action points following safeguarding meetings.

This charge is found proved.

The panel considered this charge in its entirety. In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 2 and Ms 4.

The panel had sight of Ms 2's witness statement in which she stated the following:

> *'In April 2019, I became aware that the [Colleague A] and deputy manager had attended four external safeguarding meetings. The [Colleague A] and deputy manager had fed back to me that no action points were set in the meetings. I contacted the Islington Safeguarding Team as I was concerned at the fact no actions had been set. [Mr 8] had chaired two out of four safeguarding meetings. He informed me that there were in fact actions and outcomes set, and that these could not have been made clearer to the [Colleague A] and deputy manager in the meetings.'*

The panel also had sight of the email Ms 2 sent to Mr 8 in April 2019.

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

> *'SOVA was not being followed by the Registrant, including not raising referrals with the safeguarding authority when necessary. One example was reported to me…a resident missed their medication as it had not yet arrived from the pharmacy. This was reported to me by [Ms 1], I have no further details. This should have been investigated and raised as a safeguarding but was not.'*

The panel also heard oral evidence from Ms 2 and Ms 4. Ms 2 and Ms 4 stated that Mrs Kelliher had a responsibility to take action on safeguarding issues where SOVA applied. However this did not happen. The panel found the evidence of Ms 2 and Ms 4 to be consistent, credible and reliable. The panel therefore found that Mrs Kelliher was

responsible for taking action on safeguarding issues where SOVA applied. As this had not been implemented, the panel found this charge proved.

Charge 29

29. Did not demonstrate that you took seriously concerns raised.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the evidence of Ms 4 and Ms 6.

The panel had sight of Ms 6's witness statement in which she stated the following:

> *'…Both the Registrant and the deputy manager did not like that I was raising concerns.*

The panel had sight of Ms 4's witness statement in which she stated the following:

> *…[Ms 1] and [Ms 2] put plans in place to improve the home but reported that the Registrant and [Colleague A] were dismissive in relation to suggested improvements. Action plans were never carried out…'*

The panel heard oral evidence from Ms 1, Ms 2, Ms 3 and Ms 6, all of whom found that Mrs Kelliher did not demonstrate that she took concerns raised to her seriously. The panel found the witnesses to be consistent, credible and reliable. The panel therefore found that it was more likely than not that Mrs Kelliher did not take concerns raised to her seriously. Accordingly, the panel found this charge proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

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

Mr Kennedy identified the specific, relevant standards where in his submission, Mrs Kelliher's actions amounted to misconduct. He submitted that Mrs Kelliher is an

experienced nurse and as a deputy manager and clinical lead, she had a duty to ensure that staff were competent and up to date with training, policies and procedures. Mr Kennedy submitted that in failing to maintain standards of care and take concerns raised by third parties seriously, Mrs Kelliher's actions and omissions fell well below the standards expected of a registered nurse and deputy manager and amounted to misconduct.

Submissions on impairment

Mr Kennedy 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).

Mr Kennedy submitted that limbs a, b and c of the test set out in the case of *Grant* are engaged. He submitted that Mrs Kelliher's misconduct caused actual harm to Patient C and Patient W and posed a real risk of harm to other residents in her care. Mr Kennedy submitted that not giving medication in accordance with prescriptions, food not being prepared in accordance with care plans and staff competence not being checked properly all have the potential to cause serious harm to residents. He submitted that the public would be appalled at the fact that the deputy manager of the Home did not take action and allowed poor practice to take place and continue.

Mr Kennedy submitted that Mrs Kelliher has not provided any evidence of insight or remediation. He therefore submitted that there is a risk of repetition of the misconduct and Mrs Kelliher's practice is impaired on public protection and public interest grounds.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
>
> ***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.*
>
> ***2.6*** *recognise when people are anxious or in distress and respond compassionately and politely.*
>
> ***3.1*** *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.*
>
> ***4.3*** *keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process.*
>
> **5 Respect people's right to privacy and confidentiality**
>
> ***5.1*** *respect a person's right to privacy in all aspects of their care.*
>
> ***6.2*** *maintain the knowledge and skills you need for safe and effective practice.*

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.*

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

8.6 *share information to identify and reduce risk.*

10.5 *take all steps to make sure that records are kept securely.*

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.*

13.2 *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.*

14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.*

16.1 *raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices.*

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

16.3 *tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can.*

16.4 *acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.*

17.1 *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.*

18.4 *take all steps to keep medicines stored securely.*

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

20 Uphold the reputation of your profession at all times

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

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.

However, the panel was of the view that as clinical lead and deputy manager of the Home, Mrs Kelliher had a duty to ensure that the fundamentals of care were delivered to all residents in her care and that staff were supported, competent and aware of policy and procedure and she failed in that duty. The panel found that there was no evidence that Mrs Kelliher had kept herself up to date with training and, as a consequence, she placed residents at a risk of harm. The panel determined that Mrs Kelliher's failure to work with third party professionals and implement the recommended changes was serious and placed residents at risk of harm. The panel found that Mrs Kelliher's failure to act in accordance with the Mental Capacity Act (2005) and the resulting breaches of confidentiality were serious.

The panel was of the view that Mrs Kelliher's actions and omissions in delaying referring residents to the tissue viability nurse and SALT as well as delaying ordering a humidifier for a resident with a tracheostomy, placed residents at a risk of harm and was serious. The panel was also of the view that failing to work with multi-disciplinary teams to ensure that residents were provided with the correct care and treatment was serious.

The panel determined that Mrs Kelliher's failure to ensure that medication was safely stored and administered raise serious concerns about patient safety. The panel was of the view that inadequate risk assessments and failing to ensure that incidents were reported properly also raises serious patient safety concerns. The panel was also of the view that in not investigating allegations that a resident was scared of a nurse, Mrs Kelliher failed to put the needs of that resident first and placed the resident at a risk of harm.

Having regard to all of the above, the panel found that Mrs Kelliher's actions 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, Mrs Kelliher's fitness to practise is currently impaired.

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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, b and c engaged.

The panel found that Mrs Kelliher's misconduct caused actual harm to two residents and placed multiple residents at a risk of harm over a significant period of time. The residents in Mrs Kelliher's care were put at risk of harm through poor practice in failing to seek expert review and assessment from either the tissue viability nurse or SALT. By not ensuring medication was administered in accordance with prescriptions, the wrong amounts of thickener were used which could lead to choking and aspiration and which risked fatal consequences. The panel also found that Mrs Kelliher's misconduct placed residents at risk of harm by not ensuring that staff were competent, aware of policies and procedures and reporting incidents.

The panel found that Mrs Kelliher's misconduct was serious and concluded that a fully informed member of the public or fellow nurse would be alarmed to hear about the

inadequate care provided to the residents at the Home. The panel determined Mrs Kelliher's misconduct breached fundamental tenets of the profession and brought the reputation into disrepute.

The panel was of the view that the misconduct found, as primarily clinical in nature, is potentially remediable. However, the panel was mindful that when shortfalls were identified by third parties, Mrs Kelliher did not take the opportunity to remediate the concerns and to implement change. The panel was also mindful of its findings in respect of Mrs Kelliher not taking the concerns seriously and considered that the misconduct could potentially be attitudinal in nature and therefore more difficult to remediate.

The panel had no information about any steps Mrs Kelliher may have taken to strengthen her practice or any information about her current level of insight.

Having regard to all of the above, the panel concluded that there is a risk of repetition of the misconduct and a consequent risk of harm. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel determined that a finding of impairment on public interest grounds is required as given the seriousness and nature of this case, public confidence in the profession would be undermined if a finding of impairment were not made. The panel therefore found Mrs Kelliher's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Kelliher's fitness to practise is currently impaired on public protection and public interest grounds.

Sanction

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

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

Submissions on sanction

Mr Kennedy informed the panel that the NMC sanction bid is that of a suspension or striking off order. He set out some factors that are aggravating and mitigating in his submission. Mr Kennedy submitted that the matters found proved are serious, wide-ranging, they have not been remediated and Mrs Kelliher has not provided any evidence of insight.

Mr Kennedy informed the panel that before this hearing Mrs Kelliher made an application for Agreed Removal on the basis that she is now retired and does not wish to return to nursing. Mr Kennedy referred the panel to the SG and submitted that the choice of sanction to impose is ultimately a matter for the panel.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The misconduct was serious, wide-ranging and related to fundamental nursing practice.
- The pattern of misconduct persisted months after concerns were raised.
- Mrs Kelliher failed to implement the recommended changes and actions agreed with external agencies and failed to preserve safety and act in the best interests of the residents.
- Mrs Kelliher's actions and omissions caused harm to two residents.
- A high number of extremely vulnerable residents with complex needs, some of whom lacked capacity, were put at risk of serious harm through Mrs Kelliher's actions and omissions.
- Mrs Kelliher has not demonstrated any insight or remorse into her misconduct.

The panel decided that there were no mitigating features in this case. It was of the view that Mrs Kelliher's long career as a registered nurse meant that she should have had the skills, knowledge and expertise to provide the best possible care to residents or to seek help when necessary.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Kelliher's practice would not be appropriate. 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 Mrs Kelliher's misconduct was far from being 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 Mrs Kelliher's registration would be a sufficient and appropriate response.

Whilst many of the concerns were clinical in nature, and as such could be expected to be remediated through retraining, given the lack of engagement and Mrs Kelliher's stated position that she has no desire to return to nursing, the panel determined that a conditions of practice order would be inappropriate in the particular circumstances of this case. Mrs Kelliher was the clinical lead and deputy manager of the Home and had responsibility for ensuring the safety and wellbeing of the residents in her care. The panel found that even when a multitude of concerns about the Home and patient safety were raised, Mrs Kelliher did not take these seriously and allowed poor practice to continue, which caused actual harm to two residents and placed a number of very vulnerable residents at a risk of serious harm. The panel noted that Mrs Kelliher has not provided any evidence of insight and remorse or up to date information to suggest that she is willing to engage and to strengthen her practice.

The panel is therefore of the view that there are no practical or workable conditions that could be formulated for the reasons set out above. The panel concluded that the placing of conditions on Mrs Kelliher's 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 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 found that Mrs Kelliher's misconduct was not isolated. It occurred prior to concerns being raised in January 2019, and then persisted until she resigned from her post at the Home in April 2019 despite having the opportunity to address the concerns and implement change. This unwillingness to comply with recommendations from experienced and senior colleagues demonstrates and attitude that cannot be easily remedied. The panel has been provided with no evidence to suggest that Mrs Kelliher feels any remorse for her failings or that she now understands the impact they had on residents and their families, her colleagues, the nursing profession and the wider public confidence in that profession. Having found that Mrs Kelliher did not take the concerns seriously, the panel was of the view that her behaviour in knowingly continuing to place very vulnerable residents at a risk of harm was indicative of a deep-seated attitudinal problem.

Whilst there has been no repetition of the behaviour since the charges occurred, the panel noted that Mrs Kelliher has not worked as a registered nurse since she resigned from her post in April 2019. The panel noted that given that misconduct occurred after concerns were initially raised in January 2019, Mrs Kelliher repeated the misconduct at the time in question. Given Mrs Kelliher's lack of insight and all of the above, the panel determined that there is a high risk of repetition of the misconduct and a consequent risk of harm to patients.

In the light of the above, 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?*

Mrs Kelliher, as the clinical lead, deputy manager and registered nurse had a duty to ensure the wellbeing and safety of patients. The panel found that Mrs Kelliher demonstrated a disregard for the fundamental principles of nursing, she did not:

- Act with kindness.
- Prioritise people.
- Practise effectively.
- Promote professionalism and trust.

Mrs Kelliher's actions were serious departures from the standards expected of a registered nurse and are incompatible with her remaining on the register.

The panel was of the view that the findings in this particular case demonstrate that Mrs Kelliher's actions were serious and to allow her to continue practising would not protect patients and it 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 Mrs Kelliher's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves, the panel has concluded that nothing short of this would be sufficient in this case.

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

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy who invited the panel to impose an interim suspension order for a period of 18 months. He submitted that if an appeal is made the substantive order will not come into force for that appeal period and the public would not be protected and the wider public interest would not be satisfied.

Mr Kennedy submitted than an interim suspension order would be appropriate in the circumstances. He submitted that if an appeal is made, this can often take a considerable amount of time to be heard by the High Court and therefore an 18 month interim suspension order is necessary to cover the appeal period. He submitted that if no appeal is made, then the substantive order will take effect at the end of the 28 day appeal period.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It was of the view that to not impose an interim order would be inconsistent with its previous findings.

The panel concluded that an interim conditions of practice order would not be appropriate, proportionate or workable for the reasons set out in it's determination on sanction. The panel decided to impose an interim suspension order to protect the public and meet the public interest considerations of this case, for a period of 18 months to cover the appeal period, should any appeal be made.

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

This will be confirmed to Mrs Kelliher in writing.

That concludes this determination.