Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 11 September 2023 – Friday, 15 September 2023
Monday, 18 September 2023 – Friday, 22 September 2023
Monday, 2 October 2023 – Tuesday, 3 October 2023
Tuesday, 12 December 2023 – Thursday, 14 December 2023

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	Mariana Angelova Svetlinska
NMC PIN	05J0352O
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing – 17 October 2005
Relevant Location:	Bournemouth, Christchurch and Poole
Type of case:	Misconduct
Panel members:	Des McMorrow (Chair, Registrant member) Kathryn Smith (Registrant member) Paul Leighton (Lay member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Stanley Udealor
Nursing and Midwifery Council:	Represented by Leeann Mohamed, Case Presenter (11 September 2023 – 3 October 2023) Debbie Churaman (12 – 14 December 2023)
Mrs Svetlinska:	Not present and not represented at the hearing
Facts proved:	Charges 1b, 1e, 1f, 1g, 1j, 1k, 2a, 2b, 4d
Facts not proved:	Charges 1a, 1c, 1d, 1h, 1i, 1l, 1m (i), 1m (ii), 1n, 2c, 2d (i), 2d (ii), 2d (iii), 2e, 3a, 3b, 3c, 3d (i), 3d (ii), 3d (iii), 3d (iv), 3d (v), 3d (vi), 3e, 3f, 3g, 3h, 4a, 4b, 4c
Fitness to practise:	Impaired

Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Svetlinska was not in attendance and that the Notice of Hearing letter had been sent to Mrs Svetlinska's registered email address by secure email on 10 July 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and venue of the hearing and, amongst other things, information about Mrs Svetlinska'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 Svetlinska has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Svetlinska

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

Ms Mohamed drew the panel's attention to the email from Mrs Svetlinska to the NMC, dated 9 June 2023, which stated:

'…I apologize, I will not be attending the hearing.'

Ms Mohamed stated that it has been confirmed by Mrs Svetlinska that she will not be attending the substantive hearing, nor will she be represented. She submitted that Mrs Svetlinska has voluntarily absented herself from today's hearing and has not requested an adjournment of this matter. Ms Mohamed submitted that there is a strong public interest in the expeditious disposal of the case as the charges relate to events that occurred in 2018. She submitted that it was fair for the hearing to proceed in the absence of Mrs Svetlinska.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *GMC v Adeogba* [2016] EWCA Civ 162

The panel has decided to proceed in the absence of Mrs Svetlinska. In reaching this decision, the panel has considered the submissions of Ms Mohamed, the email from Mrs Svetlinska dated 9 June 2023 and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Svetlinska indicated in her email dated 9 June 2023, that she is

aware of today's hearing and is content for the hearing to proceed in her absence;

- Mrs Svetlinska has voluntarily absented herself;
- No application for an adjournment has been made by Mrs Svetlinska;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses are scheduled to give live evidence;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018 and 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 Svetlinska in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, Mrs Svetlinska will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Svetlinska's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charges

That you, a registered nurse between 12 February 2018 and 28 March 2018, whilst working in your capacity as home manager:

1) Failed in your duty to:

    a) Ensure residents had access to call bells to summon staff;
    b) Ensure residents were being re-positioned as required;
    c) Ensure appropriate pressure alarm mats were being used for residents living with dementia;
    d) Ensure residents pain needs were being assessed and met appropriately;
    e) Ensure residents toilet and incontinence needs were being met;
    f) Ensure prescribed medications were being applied/administered;
    g) Ensure residents were being provided with adequate hydration;
    h) Ensure residents were being treated with dignity;
    i) Ensure resident's wishes and preferences were being sought and accommodated;
    j) Ensure resident's care was being delivered in line with their care plans;
    k) Ensure residents personal and hygiene care needs were being met;
    l) Ensure residents were being provided with a diet suited to their needs;
    m) Ensure residents were living in an environment which was:
        i) Hygienic;
        ii) Safe from infection risks

    n) Ensure resident's requests for pain relief were met;

2) Failed in your duty to:

    a) Ensure residents fluid and food records were accurate;

b) Ensure residents records were accurately completed without falsification;

c) Ensure medication administration records were accurately completed without falsification;

d) Ensure care plans were:

   i) Accurate;

   ii) Referring to the correct resident;

   iii) Reflecting residents needs

e) Adequately record complaints

3) Failed in your duty to:

a) Maintain adequate staffing levels, alternatively

b) Whistle-blow concerns relating to inadequate staffing levels;

c) Deploy available staff according to resident's needs;

d) Ensure staff were provided with adequate training and instruction including in relation to:

   i. Induction training

   ii. Medication administration

   iii. Dementia

   iv. Mental health/psychiatric conditions

   v. Mental capacity assessments

   vi. Making best interest decisions for residents

e) Ensure staff understood and complied with bed rail risk assessments;

f) Ensure staff had sufficient understanding of the English language to provide safe care, alternatively

g) Whistle-blow concerns regarding staff with insufficient English language proficiency;

h) Ensure safeguarding and immigration checks were completed before staff started working at the home

4) Failed in your duty to:

a) Deal appropriately and/or at all to complaints,
b) Identify and/or report safeguarding concerns;
c) Act without delay on requests by other professionals;
d) Take action to avoid further harm being suffered by a resident when notified of such harm by an Inspector of the Care Quality Commission.

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

Background

The charges arose whilst Mrs Svetlinska was working as the Registered Home Manager of Merstone Hall Care Home ('the Home'). The NMC received a referral on 29 March 2018 from the Care Quality Commission ('CQC') about concerns raised about the Home.

It was alleged by the CQC that it had received a whistleblowing letter on 12 February 2018 which highlighted a number of concerns within the Home.

The CQC conducted an unannounced inspection of the Home on 19 February 2018, and subsequently, carried out further inspections on 20 and 22 February 2018. During the inspection, the CQC raised serious concerns regarding the care given to residents as well as their safety and wellbeing. It was alleged that:

- residents were being left without access to call bells;
- residents were being washed and dressed in day clothes and being left in bed;
- residents were not being repositioned;
- food and fluid records were falsified during the inspection or were inaccurate;
- one resident was calling out complaining of pain, saying they needed the toilet and complaining of itchy skin. The resident was ignored, their pain was not assessed, and no PRN medication was administered;
- residents were not treated with dignity. Their privacy was not maintained;
- residents with pressure damage were not sat on pressure relieving cushions as detailed in their care plans and some residents' pressure relieving mattresses were set on the wrong setting for their weight;
- residents were unkempt, their hair was greasy and long and they had dirty fingernails and hands;
- care plans were inaccurate and did not reflect the residents' needs;
- medication was not given on time;
- staff did not have the skills and knowledge to meet people's needs;
- some staff were unable to understand or speak English;

- there was a poor understanding of Mental Capacity Assessments and making Best Interest Decisions for residents;
- residents had a poor lunchtime experience. Staff did not communicate with residents;
- the environment was poor and presented significant infection prevention risks;
- there was significant lack of management and oversight of the care and treatment that residents received or observation of how the nursing and care staff supported and cared for people.

It was alleged that at the end of each inspection day, Mrs Svetlinska was informed of the concerns raised and immediate actions that were required by the CQC. Mrs Svetlinska was informed by the CQC inspectors that if she had any concerns to raise about the Home, she could whistle-blow such concerns, but she did not.

At the end of the inspection, the Home was placed on an action plan to rectify these concerns, and this was supported by Bournemouth Borough Council. The CQC also made three safeguarding alerts in regard to the care and treatment of residents.

It was alleged that in the following weeks after the inspection, multi-agency professionals reported back to the CQC that little to no progress was being made and a deterioration in the care and treatment of residents had been identified despite the action plan. Therefore, a further CQC inspection was conducted on 12 March 2018.

It was alleged that on 12 March 2018, the CQC identified that there had been no improvements, and it raised a further thirteen safeguarding alerts in relation to the care and treatment of residents.

On 13 March 2018, the CQC served a notice of proposal to cancel the Home's registration and it informed the Homeowner that they were considering prosecution for offences under the Health and Social Care Act 2008. The CQC also requested a further immediate action plan on how Mrs Svetlinska as Registered Home Manager would safeguard the residents. It was alleged by the CQC that Mrs Svetlinska failed

to acknowledge her responsibilities as the Registered Home Manager in relation to the care and treatment of residents. The Home was further provided with support from Dorset Healthcare Foundation Trust and Bournemouth Borough Council safeguarding and contract monitoring team.

On 18 March 2019, the Homeowners informed the CQC that they would be closing the Home on 28 March 2018.

Decision and reasons on facts

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

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

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:

- Witness 1: CQC Inspector at the time of the incidents.
- Witness 2: Quality Assurance Facilitator at Dorset Clinical Commissioning Group at the time of the incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1a

1) Failed in your duty to:

a) Ensure residents had access to call bells to summon staff.

This charge is found NOT proved.

The panel took into account that the CQC stated in its *Inspection Report* that:

> *'On our arrival at 7am on the first day of inspection people did not have access to their call bells so they could seek assistance from staff. On the third day of inspection one person's call bell was not working and this had not been identified by staff. People were put at risk because they could not seek staff support when they needed it. People sat in the lounge did not have access to a call bell or the means of calling for staff assistance. On the third day of the inspection one person needed assistance and we found them the lounge call bell and gave it to them so they could seek assistance. On the fourth day of the inspection most people had access to their call bells. However, we needed to seek staff assistance for some people because they couldn't reach their call bell or they needed staff assistance and they were not able to independently use the call bell…'*

The panel noted that an example of such incident was described by Witness 1 in her supplementary witness statement dated 15 March 2022 where she stated:

> *'…When I arrived at Merstone at 7 AM on 19 February 2018 I noted that Resident C was already fully dressed and in bed but that she did not have a call bell...'*

Witness 2 also stated in her witness statement dated 24 October 2018 that:

> *'In the lounge, over the lunch period, one resident was heard calling for help and the toilet for an extended period of time, this was brought to the attention of the staff at the time, it was noted that she did not have a call bell within her reach.'*

The panel was satisfied that it was Mrs Svetlinska's responsibility as the registered manager of the Home to take reasonable steps to ensure that residents who were able to use them, had access to call bells to summon staff.

The panel had sight of the care plan of Resident C which stated: *'Resident C unable to use her call bell, So staffs need to check her regularly.'* sic

When this issue was brought to the attention of Witness 1 during cross-examination, she told the panel that she was not aware of such provision in Resident C's care plan at the time of the CQC inspection.

The panel further noted that the same provision was applicable to Resident B in her care plan as it was stated in her care plan that: *'Resident B has a call bell in her room but she is unable to use/ remember how to use, so staff check her hourly through the day and night…'*

The panel determined that there was insufficient evidence to demonstrate that residents who were able to use their call bells, lacked access to call bells to summon staff. Accordingly, charge 1a is found not proved.

Charge 1b

1) Failed in your duty to:

    b) Ensure residents were being re-positioned as required.

This charge is found proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'A second resident was not repositioned or given any fluids from 8am to 2pm and then records were completed after this time to show they had drank and been repositioned when they had not been'

'As such on 12th March 2018 myself and another inspector returned to the care home specifically to conduct welfare checks on all the residents so we could assess for ourselves whether any urgent regulatory action was required. We discovered that conditions had deteriorated and more residents had been placed at risk of further harm. Residents were not receiving fluids, being taken to the toilet or having their incontinence wear changed, they were not being repositioned as directed by their care plans…..'

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

'….When I arrived at Merstone at 7 AM on 19 February 2018 I noted that Resident C was already fully dressed and in bed…. The position chart had not been completed to note her position and her bed was set for 25 kilograms of weight when it should have been 60-75 kilograms. Resident C also should have had a special recliner chair but this was not in her room. During the day Resident C was moved into the lounge but then was not repositioned…... This would have caused pain for her and could have led to pressure sores as the chair she was on did not have a pressure relieving pad on it. Resident C could not have repositioned herself and would have needed the staff to help her…'

'Regarding Resident E, ….I had concerns that ….he was not being repositioned as per his care plan…'

'Regarding Resident F, …. concerns were raised about inaccurate and falsified records, that she was not being repositioned or given personal care as directed by her care plan, ….I had noted that Resident F was sitting upright in bed at 8 AM and was still in the same position at 2 PM with the same amount of squash juice next to her as in the morning. Around 2 PM a staff member came in and recorded that she had drank 300 mls and eaten some

biscuits and also been repositioned to her side. However, this was inaccurate and had not happened. Resident F had no stimulation whilst in her bedroom and in the lounge.'

The panel noted that similar concerns were raised by Witness 1 in her supplementary witness statement in that Residents G, I and L were not repositioned in accordance with their respective care plans. Mrs Svetlinska also contributed to an action and development plan as required by the CQC to address the concern.

The panel had regard to the repositioning and personal care records for Residents C, E, F, G, I and L. It also had sight of their daily records. The panel took into account that the respective records indicated that the respective residents were being repositioned in accordance with their care plans. However, it noted that these records are in contrast with the observations of Witness 1.

The panel took into consideration that Mrs Svetlinska as the registered manager of the Home, had the responsibility for the day-to-day management of the Home including activities of the staff and daily care of the residents. It was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that staff performed their duties effectively with respect to repositioning of residents when required. As the registered manager, it was Mrs Svetlinska's duty to ensure that residents' care plans with regards to repositioning were followed, records on residents' repositioning were accurately completed by staff without falsification and that the system in place at the Home to deliver care to the residents was functioning effectively.

The panel took into account that Mrs Svetlinska also acted in the capacity of a registered nurse at the Home. It had sight of the Home's staff rota and noted that Mrs Svetlinska regularly acted as the second nurse on duty. The panel was of the view that as Mrs Svetlinska also worked as a registered nurse on duty at the Home, she had an additional responsibility to ensure that residents were being repositioned in accordance with their care plans.

The panel noted that Mrs Svetlinska, as the registered manager, was provided with daily feedback by the CQC of their concerns about the Home. Witness 1 also stated that the concerns in relation to repositioning of residents had not been addressed when the CQC returned for a further inspection in March 2018.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that Mrs Svetlinska failed in her duty to ensure residents were being re-positioned as required. Accordingly, charge 1b is found proved.

Charge 1c

1) Failed in your duty to:

    c) Ensure appropriate pressure alarm mats were being used for residents living with dementia.

This charge is found NOT proved.

The panel considered the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'There was no understanding of positive risk taking or risk management. Black pressure alarm mats were in place for residents who were at risk of falls. This was dangerous as people living with dementia may think they are a black hole and step over them. One resident told me they stepped around and over the pressure mat to stop it going off, which increased their risk of falling.'*

Witness 1 further stated in her oral evidence that although the black pressure alarm mats at the Home was functioning, it was good practice to use pressure mats that had the same colour as the floor for residents living with dementia.

The panel was of the view that, although Witness 1 had stated that it was good practice to use pressure alarm mats that had the same colour as the floor for residents living with dementia, Witness 1 was not a witness with expert knowledge

as to whether a pressure alarm mat of a certain colour was or was not appropriate for residents living with dementia. The panel noted that there was no expert evidence provided to demonstrate that the black pressure alarm mats were regarded as poor practice at the relevant time for residents living with dementia. Further, the panel had sight of an order for red pressure alarm mats placed subsequently to the CQC inspection once Mrs Svetlinska was alerted to the potential issue.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, charge 1c is found not proved.

Charge 1d

1) Failed in your duty to:

    d) Ensure residents pain needs were being assessed and met appropriately.

This charge is found NOT proved.

The panel took into account that Witness 1 stated in her witness statement dated 24 October 2018 that:

> *'Residents' pain was not assessed and pain relief was not administered when they complained or showed signs of being in pain.'*

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

> *'Regarding Resident B, …. we had concerns that her pain was not being assessed or that she was getting pain relief as needed. This would obviously have left her in pain. It was also evidence that…that staff ignored her when she was calling out for assistance….Resident B was living with dementia but was able to tell us that she was in terrible pain.' sic.*

'… Resident C was also supposed to have palm protectors on (according to her care plan) but these were not in place…. During the day Resident C was moved into the lounge but then was not repositioned or taken to the toilet for at least four hours. This would have caused pain for her and could have led to pressure sores as the chair she was on did not have a pressure relieving pad on it…. Resident C also had a wound on her head that was healing but there was no documentation on where she had received the wound or the treatment she should be getting.'

Witness 1 further stated during her oral evidence that she observed Resident B shouting and calling out in pain, but she was ignored by the staff at the Home.

The panel had sight of the assessment visit letter on Resident B from the Consultant Psychiatrist dated 29 January 2018. It was reported that Resident B shouted and screamed regularly without any trigger for such behaviour. It further stated that *'she lacked insight into her problems and lacked the capacity to consent to her treatment.'* The panel noted that Resident B was referred for this assessment by the Home as a result of her regular shouting incidents. It further had regard to the behaviour care plan and Antecedent Behaviour and Consequence (ABC) chart respectively for Resident B where it noted that there were records that confirmed that Resident B regularly shouted for help even when she was not in pain.

The panel also had regard to the pain assessment chart and MAR charts respectively, for Resident B. It noted that Resident B was regularly assessed for pain, pain relief medication was administered to her regularly and there were occasions she spat out such medication.

The panel had sight of the risk assessment record and the daily records for Resident C and noted that there was regular assessment of her pain needs and measures were in place to meet them including pain relief treatment, regular repositioning and continence care. There were also instructions in place for application of splint palm protectors for Resident C.

Based on the evidence before it, the panel was not satisfied that residents' pain needs at the Home were not being assessed and met appropriately. Accordingly, charge 1d is found not proved.

Charge 1e

1) Failed in your duty to:

e) Ensure residents toilet and incontinence needs were being met.

This charge is found proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'…Residents were not……being taken to the toilet or having their incontinence wear changed…'*

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

> *'…During the day Resident C was moved into the lounge but then was not ….taken to the toilet for at least four hours…'*

> *'Regarding Resident I we did not copy her records but I had concerns that she was not being….taken to the toilet as per her care plans'* sic

The same concern was raised about Resident L by Witness 1 in that Resident L was not taken to the toilet as required.

The panel had regard to the daily records for Residents C and I. It also had sight of the care plan evaluation on incontinence for Resident L. It noted that records indicated that incontinence pads were adequately provided for the residents and changed when necessary. It also noted that the residents' continence needs were

recorded as being met daily at the Home. However, the panel noted that these records are in contrast with the observations of Witness 1.

The panel took into consideration that Mrs Svetlinska as the registered manager of the Home, had the responsibility for the day-to-day management of the Home including activities of the staff and daily care of the residents. It was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that staff performed their duties effectively in meeting the toilet and incontinence needs of residents. As the registered manager, it was Mrs Svetlinska's duty to ensure that residents' care plans with regards to incontinence were followed, records on residents' incontinence were accurately completed by staff without falsification and that the system in place at the Home to deliver care to the residents was functioning effectively.

The panel took into account that Mrs Svetlinska also acted in the capacity of a registered nurse at the Home. It had sight of the Home's staff rota and noted that Mrs Svetlinska regularly acted as the second nurse on duty. The panel was of the view that as Mrs Svetlinska also worked as a registered nurse on duty at the Home, she had an additional responsibility to ensure that residents' toilet and incontinence needs were being met in accordance with their care plans.

The panel noted that Mrs Svetlinska, as the registered manager, was provided with daily feedback by the CQC of their concerns about the Home. Witness 1 also stated that the concerns in relation to incontinence needs of residents had not been addressed when the CQC returned for a further inspection in March 2018.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that Mrs Svetlinska failed in her duty to ensure residents toilet and incontinence needs were being met. Accordingly, charge 1e is found proved.

Charge 1f

1) Failed in your duty to:

f) Ensure prescribed medications were being applied/administered.

This charge is found proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'I made safeguarding alerts for three residents at the end of the day. This was because, one resident was calling out complaining of pain, saying they needed the toilet and complaining of itchy skin. Their pain was not assessed and no PRN pain relief was administered. Creams prescribed by dermatologist had not been applied….'*

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

> *'There were also concerns around Merstone Hall about their medicines management. They had thickening powder left unattended, residents were not getting their medications at correct times, not getting creams applied as prescribed as well as some prescribed PRN medication not having documentation on when staff should be giving the medication. Again, this is something that both Mrs 1 and Mariana would have been aware of.'*
>
> *'Regarding Resident B, …. we had concerns that her pain was not being assessed or that she was getting pain relief as needed. This would obviously have left her in pain. It was also evidence that Resident B was not getting her prescribed creams….'*
>
> *'Regarding Resident D, ……. Resident D also was able to tell us that she was not being given her prescribed morphine prior to her bandage changes which was causing a lot of pain.'*

The panel noted that Mrs Svetlinska contributed to an action and development plan as required by the CQC to address the concern.

The panel was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that clinical staff administered/applied prescribed medications to residents at the Home when required.

The panel considered the MAR charts for Residents B and D. It noted there were considerable gaps on the MAR charts without any indication that the medications were refused by the residents or any other relevant justification. The panel was satisfied that such gaps should have been identified by Mrs Svetlinska if she had conducted regular checks and audits of MAR charts and medication administration to residents.

The panel took into account that Mrs Svetlinska also acted in the capacity of a registered nurse at the Home. It had sight of the Home's staff rota and noted that Mrs Svetlinska regularly acted as the second nurse on duty. The panel was of the view that as Mrs Svetlinska also worked as a registered nurse on duty at the Home, she had an additional responsibility to ensure that prescribed medications were being applied/administered to residents when required.

The panel noted that Mrs Svetlinska, as the registered manager, was provided with daily feedback by the CQC of their concerns about the Home. Witness 1 also stated that the concerns in relation to medication administration to residents had not been addressed when the CQC returned for a further inspection in March 2018.

Therefore, the panel determined that it was more likely than not, that Mrs Svetlinska failed in her duty to ensure prescribed medications were being applied/administered. Accordingly, charge 1f is found proved.

Charge 1g

1) Failed in your duty to:

g) Ensure residents were being provided with adequate hydration.

This charge is found proved.

The panel took account of the supplementary witness statement of Witness 1 dated 15 March 2022 in which she stated:

> *'Regarding Resident L, we did not copy her records but we made notes in our inspection records. I was concerned that she was not …. given anything to drink for over four hours.'*

The panel noted that the daily records of Resident L showed that she was provided with regular fluid daily. This was also observed in the daily records of Resident C and the food and fluid charts of Resident E. However, the panel noted that these records are in contrast with the observations of Witness 1.

Witness 1 had stated in her witness statement dated 24 October 2018 that:

> *'A second resident was not … given any fluids from 8am to 2pm and then records were completed after this time to show they had drank ….when they had not been.'*

The panel took into consideration that Mrs Svetlinska as the registered manager of the Home, had the responsibility for the day-to-day management of the Home including activities of the staff and daily care of the residents. It was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that staff performed their duties effectively in providing residents with adequate hydration. As the registered manager, it was Mrs Svetlinska's duty to ensure that records on residents' care were accurately completed by staff without falsification and that the system in place at the Home to deliver care to the residents was functioning effectively.

The panel took into account that Mrs Svetlinska also acted in the capacity of a registered nurse at the Home. It had sight of the Home's staff rota and noted that Mrs Svetlinska regularly acted as the second nurse on duty. The panel was of the view that as Mrs Svetlinska also worked as a registered nurse on duty at the Home, she had an additional responsibility to ensure that residents were being provided with adequate hydration.

The panel noted that Mrs Svetlinska, as the registered manager, was provided with daily feedback by the CQC of their concerns about the Home. Witness 1 further stated in her evidence that this issue was brought to Mrs Svetlinska's attention at the first CQC inspection in February 2018. Nevertheless, when the CQC returned for a second inspection in March 2018, the issue had not been resolved and Mrs Svetlinska was therefore required to complete an action and development plan.

Therefore, the panel determined that it was more likely than not, that Mrs Svetlinska failed in her duty to ensure that residents were being provided with adequate hydration. Accordingly, charge 1g is found proved.

Charge 1h

1) Failed in your duty to:

    h) Ensure residents were being treated with dignity.

This charge is found NOT proved.

The panel considered the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'Residents were not treated with dignity. Their privacy was not maintained, for example one person was being wheeled from shower to bedroom on a commode and they were only covered with a towel and their bottom was exposed, resident's personal care was conducted with bedroom doors open.'*

The panel noted that Mrs Svetlinska was informed about this concern, and she contributed to an action and development plan as required by the CQC to address the concern.

The panel took into account that it was recorded in the CQC inspection notes that there were positive feedback from three relatives of residents at the Home. The panel also had sight of *'thank you'* cards received from residents' families which showed appreciation for the care that residents received at the Home.

The panel noted that there was no evidence of any complaint made by any resident or their families that they were not being treated with dignity.

The panel therefore determined that there was insufficient evidence to demonstrate that residents were not being treated with dignity. Accordingly, charge 1a is found not proved. Accordingly, charge 1h is found not proved.

Charge 1i

1) Failed in your duty to:

    i) Ensure resident's wishes and preferences were being sought and accommodated.

This charge is found NOT proved.

The panel noted that the NMC had accepted that there was insufficient evidence to support this charge.

The panel agreed with this and therefore determined that charge 1i is found not proved.

Charge 1j

1) Failed in your duty to:

j) Ensure resident's care was being delivered in line with their care plans.

This charge is found proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'Residents with pressure damage were not sat on pressure relieving cushions as detailed in their care plans.'*

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

> *'Another concern was that the staff did not follow the care plans for the residents. Most of the time the care plans looked fine on face value but the care was not being delivered as prescribed. Again, …(Mrs 1)… and Mariana would have been aware of this as it was not hidden by the staff.'*
>
> *'Regarding Resident F, …. concerns were raised ….that she was not being repositioned or given personal care as directed by her care plan, ….the dentist and GP care plan wasn't being followed and that she was not getting her prescribed medications…'*
>
> *'Regarding Resident I we did not copy her records but I had concerns that she was not being repositioned or taken to the toilet as per her care plans'* sic

The panel noted that Mrs Svetlinska contributed to an action and development plan as required by the CQC to address the concern.

With respect to Resident F, the panel had sight of the repositioning charts, activity records, daily records, dental report, care plan evaluation records on oral care, personal care and medication respectively. The panel noted that the respective

records indicated that Resident F's care was being delivered in accordance with her care plans on repositioning, dental care, personal care and medication accordingly.

With respect to Resident I, the panel considered the repositioning and personal care records for Resident I. It also had sight of her daily records and her care evaluation plan on personal care. The panel noted that these records indicated that Resident I's care was being delivered in accordance with her care plans on repositioning and incontinence accordingly.

However, the panel noted that the respective records are in contrast with the observations of Witness 1.

The panel took into consideration that Mrs Svetlinska as the registered manager of the Home, had the responsibility for the day-to-day management of the Home including activities of the staff and daily care of the residents. It was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that staff performed their duties effectively in providing care to residents in accordance with their respective care plans. As the registered manager, it was Mrs Svetlinska's duty to ensure that residents' care plans were followed, records on residents' care were accurately completed by staff without falsification and that the system in place at the Home to deliver care to the residents was functioning effectively.

The panel took into account that Mrs Svetlinska also acted in the capacity of a registered nurse at the Home. It had sight of the Home's staff rota and noted that Mrs Svetlinska regularly acted as the second nurse on duty. The panel was of the view that as Mrs Svetlinska also worked as a registered nurse on duty at the Home, she had an additional responsibility to ensure resident's care was being delivered in line with their care plans.

The panel noted that Mrs Svetlinska, as the registered manager, was provided with daily feedback by the CQC of their concerns about the Home. Witness 1 also stated that the concerns had not been addressed when the CQC returned for a further inspection in March 2018.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that Mrs Svetlinska failed in her duty to ensure that resident's care was being delivered in line with their care plans. The panel therefore found charge 1j proved.

Charge 1k

1) Failed in your duty to:

k) Ensure residents personal and hygiene care needs were being met.

This charge is found proved.

The panel considered the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'Some residents were unkempt, their hair was greasy and long and they had dirty fingernails and hands.'

'One resident's feet were pressing on the end of the end of the bed base. They had a pressure sore on their heel, they were diabetic and had long and overgrown nails…'

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

'Regarding Resident F, …. concerns were raised ….that she was not …. given personal care as directed by her care plan, that she had unexplained injuries and bruising that were not recorded or explored by the staff, poor oral care and the dentist and GP care plan wasn't being followed … Her fingernails were unkempt and dirty….'

In relation to Relative F, the panel took into account her activity records, daily records, dental report and care plan evaluation on personal care. The panel noted that the

respective records indicated that Resident F's personal care and hygiene needs were met by the Home. It noted that the *Record of General Practitioner (GP) Visits* stated that Resident F *'looked well cared for.'*

The panel had sight of the *Contact with Multidisciplinary Team & Other Medical Professionals* records which showed that Resident F had on one occasion refused podiatry treatment while her *Chiropody Patient Record Card* showed that her nails were cut and filed albeit with some resistance from Resident F.

The panel also had regard to the risk assessment records for Resident F which showed that she was admitted into the Home with grade two pressure sore and was prone to have pressure sores and skin problems. Furthermore, the panel noted that an accident/incident form was completed for Resident F which stated that *'During personal care staff noted that (Resident F) had a skin tear to her right lower arm.'* sic The panel was of the view that these records demonstrated that Resident F's care needs were recorded and escalated by the staff at the Home.

The panel noted that the daily records for Residents G and I also indicated that their respective personal and hygiene care needs were being met at the Home.

However, the panel noted that these records are in contrast with the observations of Witness 1.

The panel took into consideration that Mrs Svetlinska as the registered manager of the Home, had the responsibility for the day-to-day management of the Home including activities of the staff and daily care of the residents. It was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that staff performed their duties effectively in meeting the personal and hygiene care needs of residents. As the registered manager, it was Mrs Svetlinska's duty to ensure that residents' care plans with respect to personal and hygiene care were followed, records on residents' personal and hygiene care were accurately completed by staff without falsification and that the system in place at the Home to deliver care to the residents was functioning effectively.

The panel took into account that Mrs Svetlinska also acted in the capacity of a registered nurse at the Home. It had sight of the Home's staff rota and noted that Mrs Svetlinska regularly acted as the second nurse on duty. The panel was of the view that as Mrs Svetlinska also worked as a registered nurse on duty at the Home, she had an additional responsibility to ensure that residents' personal and hygiene care needs were being met in accordance with their care plans.

The panel noted that Mrs Svetlinska, as the registered manager, was provided with daily feedback by the CQC of their concerns about the Home. Witness 1 also stated that these concerns had not been addressed when the CQC returned for a further inspection in March 2018.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that Mrs Svetlinska failed in her duty to ensure residents personal and hygiene care needs were being met. The panel therefore found charge 1k proved.

Charge 1l

1) Failed in your duty to:

    l) Ensure residents were being provided with a diet suited to their needs.

This charge is found NOT proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'Records for a resident, who was on a pureed diet and thickened fluids showed they were having solid foods. This was supported by what the resident told us.'*
>
> *'…A resident was fed hot food whilst they were asleep, a staff member tapped their face repeatedly…'*

The panel considered the supplementary witness statement of Witness 1 dated 15 March 2022 where she stated:

> *'Regarding Resident B, …. that staff tried to feed her hot food whilst she was asleep…'*
>
> *'Regarding Resident D, …. I had concerns….that her nutrition plan was not being followed…'*
>
> *'Regarding Resident E, …. I was also concerns as Resident E told us that he was being given solid food (sausage rolls) when he was prescribed a modified soft diet. When I asked …(Mrs 1)…about this she denied he was given sold foods and stated that they pureed everything with backed beans for him. However, Resident E has capacity and I believe that he was given sold foods.'* sic

The panel took into account the witness statement of Witness 2 dated 24 October 2018 in which she stated:

> *'Some staff were observed not conversing with residents when assisting with their meals and that puree meals were being mixed together and not presented in a way that residents would be able to identify individual parts of the meal.'*

With respect to Resident B, the panel noted that Witness 1 confirmed during her cross-examination that she observed a member of staff trying to force feed Resident B while she was drowsy or sleepy. She further stated that it was poor practice to feed a drowsy or sleepy resident.

The panel had regard to the care plan on nutrition for Resident B which stated that she shows no interest in food or wanting to eat, and staff are to encourage her with her diet and fluid intake including feeding her. The panel also had sight of the daily records for Resident B which indicated that she was being fed in accordance with

her care plan on nutrition. It also showed that Resident B had refused meals on several occasions and only ate with encouragement of staff.

With regards to Resident D, the panel had sight of her care plan on nutrition which provided for normal fluids and easy chew diet for Resident D. The panel noted that the daily records for Resident D indicated that she was being fed in accordance with this care plan.

With respect to Resident E, the panel had regard to his care plan on nutrition which recommended syrup consistency fluid and puree diet for his dietary needs. The panel had sight of Resident E's daily records and care plan evaluation on nutrition records which indicated that he was being fed in accordance with his care plan on nutrition. The panel further noted that Resident E's care plan evaluation on nutrition stated that Resident E was usually coughing while being fed with his puree diet and stage one fluid.

When Witness 1 was informed about this issue during cross-examination, she accepted that it was quite unlikely that a resident who coughed when given fluids or puree meals, would be given unpureed sausage rolls by the Home. However, she insisted that she raised the concern based on the complaint made by Resident E that he was being fed with sausage rolls and she believed that he had capacity at the time of the inspections.

The panel took into account that it was stated in the *Contact with Multidisciplinary Team & Other Medical Professionals* records that the Consultant Psychiatrist had stated that Resident E lacked capacity during his mental capacity assessment at the Home.

The panel was of the view that there was insufficient evidence to demonstrate that residents were not provided with a diet suited to their needs. Accordingly, charge 1l is found not proved.

Charge 1m

1) Failed in your duty to:

m) Ensure residents were living in an environment which was:

i) Hygienic

ii) Safe from infection risks

These charges are found NOT proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'The environment was poor and presented significant infection prevention risks. There were torn and worn carpets, stained hard flooring, malodours in the lounge areas, some chairs smelt of urine, some bedrooms were malodourous and paintwork was chipped. It was not an environment that was suitable for residents living with dementia. There were no residents' names on bedroom doors and no personalised information.'*

The panel considered the witness statement of Witness 2 dated 24 October 2018 in which she stated:

> *'The malodour noted during previous inspections remained in the foyer and lounge areas.'*

> *'From the information available on the day it appears the last Infection and Prevention and Control audit was undertaken in September 2017 (the audit itself states this should be 3 monthly).'*

The panel had regard to the *Bournemouth Borough Council Contract Monitoring Report* (the Monitoring Report) dated 15 February 2018. It noted that the Home had partially met the standards on *Safe Working Practices/Health and Safety and Infection Prevention and Control* respectively. In the *Infection Prevention and Control standard,* the Monitoring Report stated:

'… In one room being used by the Inspectors it was noted that there were several infection control and safety issues including exposed pipes under the sink, an unsafe glass shelf and a length of missing skirting board, these were brought to the attention of the Manager and were in the process of being rectified during the second day of the visit which is positive.

It is positive that the home has adapted the Infection Control Policy from the CCG however it there are some gaps in ensuring it refers to local procedures and contact in places (from page 15 onwards).'

'… All Staff had received Infection Control Training.'

The panel was satisfied that the Monitoring Report demonstrated that there was a system at the Home to ensure that residents were living in an environment which was hygienic and safe from infection risks. Although, this standard was not fully met at the time of the Monitoring Report, there were measures taken at the Home to rectify such gaps identified in those areas of concerns.

Based on the evidence before it, the panel was not satisfied that Mrs Svetlinska had failed to take reasonable steps to ensure that residents were living in an environment which was hygienic and safe from infection risks. Accordingly, charges 1m (i) and 1m (ii) are found not proved.

Charge 1n

1) Failed in your duty to:

n) Ensure resident's requests for pain relief were met.

This charge is found NOT proved.

The panel took into account that Witness 1 stated in her witness statement dated 24 October 2018 that:

‘Residents' pain was not assessed and pain relief was not administered when they complained or showed signs of being in pain.’

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

‘… Resident D also was able to tell us that she was not being given her prescribed morphine prior to her bandage changes which was causing a lot of pain.’

The panel noted that Resident D was the only resident identified by the CQC to raise this concern. Therefore, the panel had regard to the various MAR charts for Resident D. It noted that there were records from the week starting on 8 January 2018 which confirmed that morphine and paracetamol were administered to Resident D prior to wound dressing and relief for pains. It further noted that there were occasions where Resident D had refused such pain relief medication, for example, on 24 March 2018, it was recorded on the MAR chart that Resident D had refused morphine twice.

The panel was of the view that there was insufficient evidence to demonstrate that resident’s requests for pain relief were not met at the Home. Accordingly, charge 1n is found not proved.

Charge 2a

2) Failed in your duty to:

a) Ensure residents fluid and food records were accurate.

This charge is found proved.

The panel considered the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'….Some residents repositioning, food and fluid records were falsified during the inspection and or were inaccurate.'

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

'Regarding Resident F, …. concerns were raised about inaccurate and falsified records, ….I had noted that Resident F was sitting upright in bed at 8 AM and was still in the same position at 2 PM with the same amount of squash juice next to her as in the morning. Around 2 PM a staff member came in and recorded that she had drank 300 mls and eaten some biscuits and also been repositioned to her side. However, this was inaccurate and had not happened. Resident F had no stimulation whilst in her bedroom and in the lounge.'

The panel took into consideration that Mrs Svetlinska as the registered manager of the Home, had the responsibility for the day-to-day management of the Home including activities of the staff and daily care of the residents. It was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that residents' food and fluid records were accurately completed by staff without falsification.

The panel noted that Mrs Svetlinska, as the registered manager, was provided with daily feedback by the CQC of their concerns about the Home. Witness 1 further stated in her evidence that this issue was brought to Mrs Svetlinska's attention at the first CQC inspection in February 2018. Nevertheless, when the CQC returned for a second inspection in March 2018, the issue had not been resolved and Mrs Svetlinska was therefore required to complete an action and development plan.

Therefore, the panel determined that it was more likely than not, that Mrs Svetlinska failed in her duty to ensure residents fluid and food records were accurate. Accordingly, charge 2a is found proved.

Charge 2b

2) Failed in your duty to:

b) Ensure residents records were accurately completed without falsification.

This charge is found proved.

The panel considered the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'A second resident was not repositioned or given any fluids from 8am to 2pm and then records were completed after this time to show they had drank and been repositioned when they had not been.'

'A third resident's records were inaccurate and showed they had drank and eaten when they had not.'

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

'There was also a concern regarding inaccurate records for the residents. While at Merstone Hall I saw falsification of records by staff. At one point I watched as resident who had not had anything to drink that day and a member of staff came in and recorded that they had given them something to drink. This was the culture of the service. If there had been enough oversight and observation of the care and support to residents by either …(Mrs 1)… or Mariana then they would have seen this. Anyone just walking around Merstone observing and checking would see that the records were not accurate and were being recorded inaccurately. I was shocked that the staff were not even hiding this….'

'Regarding Resident C, there were no copies of her records but from the inspection notes and other documents seen during the inspection there were concerns that her records were inaccurate, and I also found staff were falsifying her records during the inspection…'

'Regarding Resident F, …. concerns were raised about inaccurate and falsified records, ….I had noted that Resident F was sitting upright in bed at 8 AM and was still in the same position at 2 PM with the same amount of squash juice next to her as in the morning. Around 2 PM a staff member came in and recorded that she had drank 300 mls and eaten some biscuits and also been repositioned to her side. However, this was inaccurate and had not happened. Resident F had no stimulation whilst in her bedroom and in the lounge.'

The panel noted that the same concerns were raised about records of Resident G by Witness 1 in that his records were inaccurate.

The panel took into consideration that Mrs Svetlinska as the registered manager of the Home, had the responsibility for the day-to-day management of the Home including activities of the staff and daily care of the residents. It was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that residents' records were accurately completed by staff without falsification.

The panel noted that Mrs Svetlinska, as the registered manager, was provided with daily feedback by the CQC of their concerns about the Home. Witness 1 further stated in her evidence that this issue was brought to Mrs Svetlinska's attention at the first CQC inspection in February 2018. Nevertheless, when the CQC returned for a second inspection in March 2018, the issue had not been resolved and Mrs Svetlinska was therefore required to contribute to an action and development plan.

Therefore, the panel determined that it was more likely than not, that Mrs Svetlinska failed in her duty to ensure residents records were accurately completed without falsification. Accordingly, charge 2b is found proved.

Charge 2c

2) Failed in your duty to:

c) Ensure medication administration records were accurately completed without falsification.

This charge is found NOT proved.

The panel took into account that Witness 1 stated in her witness statement dated 24 October 2018 that:

> *'MAR charts stated medicines were administered at 8 am, 12 noon, 5 pm and 10 pm but they were not administrated at these times. Time critical medicine or with a set time-period between doses was discussed with a member of nursing staff as to how it is known when to give them. The response was they know when medicines are due as there is only one nurse administering. However, a second nurse was brought in on 19 February 2018 but morning (8 am) medicines were still being administered at 11.30 am.'*

The panel noted that Mrs Svetlinska contributed to an action and development plan as required by the CQC to address the concern.

The panel was of the view that the concern raised by Witness 1 seems to border on the issue that medications were not being administered to residents when due. This concern differs from the allegation intended by this charge that medication administration records were falsified. The panel noted there was no evidence before it to suggest that medication administration records were falsified nor were such alleged false records highlighted and presented to the panel.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, charge 2c is found not proved.

Charge 2d (i)

2) Failed in your duty to:

d) Ensure care plans were:

i) Accurate.

This charge is found NOT proved.

The panel took into account that Witness 1 stated in her supplementary witness statement dated 15 March 2022 that the care records of Residents B, E and J, respectively, were inaccurate.

The panel noted that when Witness 1 was questioned about this concern during cross-examination, she accepted that the care plans were satisfactory but insisted that residents' care was not delivered in accordance with their respective care plans at the Home.

The panel was of the view that there was no evidence before it to demonstrate that Residents B, E and J's respective care plans were inaccurate. There was no evidence of complaint from their families or from their health professionals that their care plans were erroneous.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, charge 2d (i) is found not proved.

Charge 2d (ii)

2) Failed in your duty to:

d) Ensure care plans were:

ii) Referring to the correct resident.

This charge is found NOT proved.

The panel considered the witness statement of Witness 2 dated 24 October 2018 in which she stated:

> *'In all care plans reviewed there were entries that referred to other residents, for example, the care plan of a Male resident seen by the CCG included a reference to a female resident, 'XX needs support'.*

The panel was of the view that there was insufficient evidence before it to demonstrate that care plans did not refer to the correct resident at the Home. It noted that no care plan of any resident where such error occurred was identified nor highlighted to demonstrate such error.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, charge 2d (ii) is found not proved.

Charge 2d (iii)

2) Failed in your duty to:

d) Ensure care plans were:

iii) Reflecting residents needs.

This charge is found NOT proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'Care Plans …… did not reflect the resident's needs.'*

The panel noted that Mrs Svetlinska contributed to an action and development plan as required by the CQC to address the concern.

The panel was of the view that there was no evidence to demonstrate that care plans did not reflect residents' needs. It bore in mind that Witness 1 had stated during cross-examination that the care plans were satisfactory. It noted that there was no evidence from medical or health professionals to demonstrate that the care plans did not reflect the residents' needs. The panel also had sight of various residents' care plan evaluation records which indicated that residents' care plans were regularly reviewed and updated to reflect residents' needs.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, charge 2d (iii) is found not proved.

Charge 2e

2) Failed in your duty to:

e) Adequately record complaints

This charge is found NOT proved.

The panel noted that the NMC had accepted that there was insufficient evidence to support this charge.

The panel agreed with this and therefore determined that charge 2e is found not proved.

Charge 3a

3) Failed in your duty to:

a) Maintain adequate staffing levels, alternatively.

This charge is found NOT proved.

The panel noted that the NMC had accepted that there was insufficient evidence to support this charge.

The panel agreed with this and therefore determined that charge 3a is found not proved.

Charge 3b

3) Failed in your duty to:

b) Whistle-blow concerns relating to inadequate staffing levels.

This charge is found NOT proved.

The panel noted that the NMC had accepted that there was insufficient evidence to demonstrate that Mrs Svetlinska had failed in her duty to maintain staffing levels. The panel was of the view that since there was insufficient evidence to demonstrate that there were concerns relating to inadequate staffing levels at the Home, there was no duty on Mrs Svetlinska to whistle-blow on such concerns. Therefore, the panel found charge 3b not proved.

Charge 3c

3) Failed in your duty to:

c) Deploy available staff according to resident's needs.

This charge is found NOT proved.

The panel noted that the NMC had accepted that there was insufficient evidence to support this charge.

The panel agreed with this and therefore determined that charge 3c is found not proved.

Charge 3d (i)

3) Failed in your duty to:

d) Ensure staff were provided with adequate training and instruction including in relation to:

i) Induction training

This charge is found NOT proved.

The panel considered the supplementary witness statement of Witness 1 dated 15 March 2022 in which she stated:

> *'One of the biggest concerns that was raised when we inspected Merstone was related to the staffing at the Home…… There was also no evidence of proper induction for new staff or further training once at Merstone Hall….'*

The panel had sight of the staff induction training records for new members of staff at the Home. It also noted that a new member of staff was scheduled for a three-day induction training on the staff rota between 26 to 28 February 2018.

The panel was of the view that based on the evidence before it, there was a system in place at the Home to ensure continuous induction training for new members of staff. The panel therefore found charge 3d (i) not proved.

Charge 3d (ii)

3) Failed in your duty to:

d) Ensure staff were provided with adequate training and instruction including in relation to:

ii) Medication administration

This charge is found NOT proved.

The panel took into account that Witness 1 stated in her witness statement dated 24 October 2018 that:

> *'PRN medicine plans were in place but had no details of when to administer medications to residents.'*

The panel considered the *CQC Inspection Report* in which it was stated that:

> *'…We looked at the provider and registered manager's systems for assessing the skills and competencies of the nursing staff. We reviewed two of the nurses' staff files and they both last had their competency to administer medicines assessed in 2015. This meant their competency skills and knowledge in relation to medicines administration had not been assessed on an annual basis in line with NICE guidance...'*

The panel noted that Mrs Svetlinska contributed to an action and development plan as required by the CQC to address the concern.

The panel had regard to the Home's training matrix and noted that from the five registered nurses at the Home, three had completed refresher training on medication in 2017. It had sight of the letter from Tynham Training Limited to the Home dated 20 February 2018, confirming booking for training on medication safe handling for nursing staff at the Home. There was also a training schedule that showed that training on medication had been scheduled on 1 March 2018 at the Home.

Based on the evidence before it, the panel was not satisfied that Mrs Svetlinska had failed to put in place reasonable measures to ensure staff was provided with adequate training and instruction in relation to medication administration. Accordingly, charge 3d (ii) is found not proved.

Charge 3d (iii)

3) Failed in your duty to:

d) Ensure staff were provided with adequate training and instruction including in relation to:
iii) Dementia.

This charge is found NOT proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'Staff did not have the skills and knowledge to meet people's needs. They did not understand about people living with dementia…. This was because staff had not had the training to meet those needs…'

The panel considered the witness statement of Witness 2 dated 24 October 2018 in which she stated:

'It was evident that not all staff appeared to have a full understanding of the needs of residents who live with dementia, this included how to approach residents when they were distressed or calling out. This also refers to the fact both the radio and television were on simultaneously in the lounge/dining area.'

The panel had regard to the Home's training matrix and noted that there were some gaps on dementia training for some staff members at the Home. The panel noted that the Home was not registered as a dementia care home but acknowledged that there were residents with a secondary diagnosis of dementia at the Home. The panel had sight of dementia training sign-up sheets, dementia training attendance sheet and staff training certificates on dementia, respectively, from the Home.

The panel was of the view that these documents demonstrate that there was a system in place to ensure that staff at the Home were provided with adequate training on dementia. Accordingly, the panel found charge 3d (iii) not proved.

Charge 3d (iv)

3) Failed in your duty to:

d) Ensure staff were provided with adequate training and instruction including in relation to:
iv) Mental health/psychiatric conditions.

This charge is found NOT proved.

The panel considered the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'Staff did not have the skills and knowledge to meet people's needs….they were not managing residents who were living with schizophrenia. This was because staff had not had the training to meet those needs.'

The panel took account of the *CQC Inspection Report* in which it was stated that:

'…Staff told us they had received training in mental health. This was particularly important because the home was caring for some people with diagnosed complex mental health conditions. There was contradictory information in relation what staff told us they had and the training records and training certificates. For example, the staff training information we reviewed during the inspection and sent to us following the inspection did not include that any staff had received specific mental health training…'

'… Some people's needs were not fully assessed before a decision was made to admit them to the home. This had resulted in staff not being able to meet

one person's complex mental health needs because they did not have the appropriate skills and knowledge…'

The panel had regard to the training matrix and noted that not all members of staff had completed training on challenging behaviours. It noted that there were no records of staff training on specific psychiatric conditions such as schizophrenia, at the Home. However, the panel did not see evidence in the records provided by the NMC of any residents having such a diagnosis. The panel considered that it would not be reasonable to expect training to be provided for conditions which were not evident within the Home.

The panel was not satisfied that Mrs Svetlinska had failed to take reasonable steps to ensure that staff were adequately trained on mental health/psychiatric conditions. Accordingly, the panel found charge 3d (iv) not proved.

Charges 3d (v) (vi)

3) Failed in your duty to:

d) Ensure staff were provided with adequate training and instruction including in relation to:
v) Mental capacity assessments
vi) Making best interest decisions for residents

These charges are found NOT proved.

The panel considered the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'There was a poor understanding of Mental Capacity Assessments and making Best Interest Decisions for residents.'

The panel noted that Mrs Svetlinska contributed to an action and development plan as required by the CQC to address the concern.

The panel had regard to the Home's training matrix, training attendance sheet and staff training certificates on mental capacity assessments and Deprivation of Liberty Safeguards (DOLS), respectively. It was of the view that these documents demonstrate that there was a system in place to ensure that staff at the Home were provided with adequate training and instructions on mental capacity assessments and making best interest decisions for residents. Accordingly, the panel found charges 3d (v) and (vi) not proved.

Charge 3e

3) Failed in your duty to:

e) Ensure staff understood and complied with bed rail risk assessments.

This charge is found NOT proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'On arrival at 07:00 on 19 February 2018 all residents' bed rails were up regardless of whether this was the least restrictive or risk assessed option. Bed rail risk assessments were completed but there was a lack of understanding about the best practice of use of bed rails with people who are at risk of falls and the risks that residents living with dementia may climb over bedrails.'

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

'*Regarding Resident J, ….During the inspection I took …(Mrs 1)…to Resident J bedroom on 22 February 2018 and we saw him trying to climb over the bed rails and I told her how unsafe this was. However, on my next visit to*

Merstone Hall on 12 March 2018 the bed rails were still there creating a risk for Resident J.' sic

The panel took into consideration that during Witness 1's cross-examination, she accepted that not all bed rails were up during the CQC inspection. She however insisted that although the bed rail risk assessment records were satisfactory, the best practice on use of bed rails were not adopted at the Home. She stated that best practice requires that the least restrictive option should be considered before bed rails are adopted for a resident and there should be a record of such option being considered. She stated that this was not implemented at the Home.

The panel had regard to Resident J's *Falls Assessment Tool* and noted that bed rails were recommended as an intervention strategy to reduce the risk of falls out of bed for him. The panel had sight of Resident J's *Bed Rail Assessment* and *Care Plan Evaluation on Bed Rail Assessment.* It noted that these documents indicated that bed rails were used in accordance with Resident J's care plan and recommended for its continuous use to ensure his safety.

The panel was satisfied that these documents demonstrated that staff at the Home had complied with bedrail assessment for Resident J. It noted that Witness 1 had stated that the bed rail assessments were satisfactory, but her concern was that the least restrictive option was not being used at the Home. The panel was of the view that the mischief of this charge was whether there was a system in place at the Home to ensure that staff understood and complied with bed rail assessment, but not whether such bed rail assessments were appropriate.

The panel also had sight of some bed rail assessments where bed rails were not recommended, which demonstrates that the use of bed rails was not the default position in the Home.

Therefore, the panel determined that there was no evidence before it to demonstrate that staff did not understand and comply with bed rail assessments at the Home. Accordingly, charge 3e is found not proved.

Charge 3f

3) Failed in your duty to:

f) Ensure staff had sufficient understanding of the English language to provide safe care, alternatively.

This charge is found NOT proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'…. In addition, some care staff's English language skills were poor and they did not understand spoken English.'

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

'…I also had concerns about the staff as for the majority of them, English was not their first language. It is not uncommon for staff not to be native English speakers but at Merstone Hall the level of English was not sufficient to provide appropriate care to people. You could ask staff a basic question and they would not be able to answer. This can happen, so you would just rephrase the question but in this instance they still could not answer. This was concerning as then the staff cannot read the resident's documents or communicate effectively. A lot of the residents at Merstone had dementia so effective communication was essential. Again, as …(Mrs 1)… was the one in charge of staffing Merstone Hall as well as her being there regularly she would have known that these staff were not able to understand both written and verbal English to give the care needed to the residents.'

The panel noted that Witness 1 stated during her cross-examination that her concerns bordered on the English language capability of two students who she

observed assisting residents with special diet needs with feeding and two other members of staff at the Home.

The panel was satisfied that there was no evidence before it to suggest that the students as identified by Witness 1, were members of staff at the Home. This charge does not cover non-members of staff such as the students at the Home. The panel noted that Witness 1 did not identify the two members of staff that had insufficient understanding of English language to provide safe care and she could not recall whether they were permanent or agency staff at the Home.

The panel had sight of the Home's staff competency assessments which included assessments on communication, register of attendance of staff at training courses on communication, staff's certificates on English language and staff's supervision records which included action plans on improving English language capability.

Based on the evidence before it, the panel was not satisfied that Mrs Svetlinska had failed to take reasonable steps to ensure that staff had sufficient understanding of the English language to provide safe care at the Home. Therefore, the panel found charge 3f not proved.

Charge 3g

3) Failed in your duty to:

g) Whistle-blow concerns regarding staff with insufficient English language proficiency.

This charge is found NOT proved.

The panel noted that it had previously found that there was insufficient evidence to demonstrate that Mrs Svetlinska had failed in her duty to ensure staff had sufficient understanding of the English language to provide safe care, alternatively. The panel was of the view that since there was insufficient evidence to demonstrate that there were concerns regarding staff with insufficient English language proficiency, there

was no duty on Mrs Svetlinska to whistle-blow on such concerns. Therefore, the panel found charge 3g not proved.

Charge 3h

3) Failed in your duty to:

h) Ensure safeguarding and immigration checks were completed before staff started working at the home.

This charge is found NOT proved.

The panel took account of the *CQC Inspection Report* in which it was stated that:

> *'…Over 50% of the care staff working at the home were employed through a staffing agency. The staff employed and appointed by the provider either directly or through a staffing agency were not recruited safely. This was because, the provider and registered manager had not ensured they had sought all the documentation and evidence as required by the regulations to make sure that staff were safe to work with people. For example, there was evidence that some staff started work at the home before ISA first and DBS checks were received. The provider told us that these staff had only worked in the kitchen and laundry and they did not have any contact with people. However, there were not any risk management plans in place or recorded about this…. . In addition, no police checks had been requested from the staff's country of origin when they had recently arrived the UK. There were also gaps in staff's employment records. For some staff who were not European citizens there was not any evidence of right to work in the UK.'*

The panel had sight of records of Enhanced Disclosure and Barring Service (DBS) and police checks conducted on immigrant members of staff at the Home. The panel noted that there was no evidence to show that these checks were not completed before staff started working at the Home.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, charge 3f is found not proved.

Charge 4a

4) Failed in your duty to:

a) Deal appropriately and/or at all to complaints.

This charge is found NOT proved.

The panel noted that the NMC had accepted that there was insufficient evidence to support this charge.

The panel agreed with this and therefore determined that charge 4a is found not proved.

Charge 4b

4) Failed in your duty to:

b) Identify and/or report safeguarding concerns.

This charge is found NOT proved.

The panel took into account that Witness 1 stated in her supplementary witness statement dated 15 March 2022 that:

'A concern was also raised about safeguarding concerns being raised and the ability for Merstone to protect the residents from abuse and harm. On my first visit to Merstone on 19 February 2018 I raised Safeguarding concerns for three people and by the end of the inspection for all of the people living at the service which shows that these issues had not been appropriately raised by

either …(Mrs 1)… or Mariana. Looking at previous Safeguarding notifications that had been made I could see that they had been raised by both …(Mrs 1)… and Mariana So both knew how and when to raise concerns. It is unusual for a nominated individual to raise Safeguarding concerns and other statutory notifications for a home (usually it is the registered manager) but this shows that …(Mrs 1)… did have a hand in the day to day running of Merstone.'

The panel had sight of evidence that indicated that previous concerns had been raised by Mrs 1 and Mrs Svetlinska. The panel noted that the Monitoring Report from Bournemouth Borough Council indicated that the Home had met the required standard on *Safeguarding Adults/Adult Protection*.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, charge 4b is found not proved.

Charge 4c

4) Failed in your duty to:

c) Act without delay on requests by other professionals.

This charge is found NOT proved.

The panel considered the witness statement of Witness 1 dated 24 October 2018 in which she stated:

'…For one resident with an infection a swab requested by the district nurses had not been taken for 11 days…'

The panel took into account that Witness further stated in her supplementary witness statement dated 15 March 2022 that:

'Regarding Resident D, ….I had concerns that the wound advice from the Tissue Viability Nurse (TVN) was not being followed, that a referral to the GP

for pain relief had not been actioned (leaving her in pain), that a swab had not been taken for four days following the District Nurse assessment…'

'Regarding Resident E, …I had concerns…that the advice from the District Nurse regarding pressure are care and nutrition was not being actioned.' Sic

'Regarding Resident F, …concerns were raised about….poor oral care and the dentist and GP care plan wasn't being followed and that she was not getting her prescribed medications...'

With respect to Resident D, the panel had sight of the daily records for Resident D and noted that there was a delay in the provision of the swab by the GP to the Home. Resident D declined for the swab to be taken as she had capacity to refuse treatment. The panel noted that Witness 1 confirmed during her cross-examination, that this record of events was accurate. However, she insisted that the swab could had been taken during the change of bandage dressing on 10 March 2018. The panel however had sight of a letter from the District Nurse Lead to the Home, dated 9 March 2018 which requested that the swab should be taken in the presence of the District Nurses.

With respect to Resident E, the panel had regard to his food and fluid charts as well as his daily records. It noted that the district nurse's advice on nutrition and pressure care were respectively being followed at the Home.

With respect to Resident F, the panel had regard to her dental report and daily records. It noted that the respective records indicated that the dental and GP care plan were being followed at the Home.

Therefore, the panel was not satisfied that the NMC had discharged the burden of proof. Accordingly, the panel found charge 4c not proved.

Charge 4d

4) Failed in your duty to:

d) Take action to avoid further harm being suffered by a resident when notified of such harm by an Inspector of the Care Quality Commission.

This charge is found proved.

The panel took account of the witness statement of Witness 1 dated 24 October 2018 in which she stated:

> *'One resident's feet were pressing on the end of the end of the bed base. They had a pressure sore on their heel, they were diabetic and had long and overgrown nails. The fact their feet were pressing on the end of the bed had been raised with the registered manager and nursing staff on 19 February 2018 but was still happening on 20 February 2018 and placed the resident at risk of pressure damage to their feet.'*

Witness 1 further stated in her supplementary witness statement dated 15 March 2022 that:

> *'…The CQC and other agencies had told both …(Mrs 1)… and Mariana that by not following protocols that they were creating risks for the residents. One example is for …(Resident A)… who we found had his feet touching the end of his bed creating pressure sores on his feet. This was noted on our first visit and yet when we visited again nothing had been done to help him or reduce his risk of further pressure sores...'*
>
> '*Regarding Resident J, ….During the inspection I took Mariana to Resident J bedroom on 22 February 2018 and we saw him trying to climb over the bed rails and I told her how unsafe this was. However, on my next visit to Merstone Hall on 12 March 2018 the bed rails were still there creating a risk for Resident J.'* sic

The panel was of the view that as Mrs Svetlinska was notified of and shown by Witness 1, harm being suffered by residents at the Home, it was her responsibility as the registered manager to take reasonable steps to ensure that further harm was not being suffered by those residents. Also, as Mrs Svetlinska worked as a registered nurse at the Home, there was an additional responsibility on her to take such action to avoid further harm being suffered by residents.

However, the panel noted that Witness 1 insisted that such concerns raised about residents were not addressed nor the risk of harm reduced when she returned for a further inspection in March 2018.

The panel was satisfied that based on the evidence before it, it was more likely than not, that Mrs Svetlinska failed in her duty to take action to avoid further harm being suffered by a resident when notified of such harm by an Inspector of the Care Quality Commission. Accordingly, it found charge 4d 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 Svetlinska'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 suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

Ms Churaman referred the panel to the case of *Roylance v General Medical Council* (No. 2) [2000] 1 AC 311 in which Lord Clyde stated:

> *'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances.'*

Ms Churaman also referred the panel to the case of *Calheam v GMC* [2007] EWHC 2606 (Admin) in which Jackson J stated:

'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired.'

Ms Churaman further referred the panel to the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) in which Collins J stated:

'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner.'

Ms Churaman submitted that Mrs Svetlinska's actions fell short of the acceptable standards required from a registered nurse and they breached 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ("the Code"). She submitted that Mrs Svetlinska had breached the following paragraphs of the Code: 1.1, 1.2, 3.1, 8.4, 8.5, 8.6, 9.1, 9.2, 10.2, 10.3, 11.1, 11.2, 11.3, 14.1, 14.2, 14.3, 19.1, 19.4, 20.1, 20.2, 20.3, 20.8, 25.1 and 25.2.

Ms Churaman submitted that Mrs Svetlinska's actions constituted misconduct in three areas:

a. Failure to ensure a number of fundamental aspects of care were delivered to the residents at the Home in the following areas: personal care; hygiene, medical care and medication administration.
b. Failure to ensure that records were accurate and not falsified.
c. Failure to take action to avoid further harm to a resident at the Home.

Ms Churaman submitted that these failings are serious and placed residents at the risk of harm.

With regards to the failings in fundamental aspects of care, Ms Churaman submitted that it was expected that Mrs Svetlinska, in her dual roles in acting as a registered nurse and registered manager at the Home, to deliver fundamentals of care to residents at the Home. However, she failed in her duty of care to the residents which placed them at risk of harm.

With respect to failings in record-keeping, Ms Churaman submitted that such failings presented an inherent risk to residents and the Home as an organisation. She submitted that the consequence of such failings was that the records could not be relied upon as an accurate document, and this would have impacted negatively on the care received by residents due to such inaccuracies. Also, any decision with respect to care of residents, made on the basis of such inaccurate records, would have placed the residents at risk of harm.

In relation to the failure to take action to avoid further harm to a resident at the Home, Ms Churaman submitted that Mrs Svetlinska, while acting in the dual capacities as registered manager and nurse at the home, failed to take action to avoid further harm to a resident when notified by the CQC. This demonstrates a breach of duty of care to residents under Mrs Svetlinska's care and placed such resident at the risk of further harm.

In conclusion, Ms Churaman invited the panel to find that the facts found proved amount to misconduct.

Submissions on impairment

Ms Churaman 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. She referred the panel to the NMC Guidance on Impairment especially the question which states:

> '*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

Ms Churaman highlighted that if the answer to this question is "yes", there is a likelihood that the nurse's fitness to practise is not impaired. She submitted that in order to answer the question, consideration should be given to the nature of the concern and the public interest.

Ms Churaman noted that impairment is a forward-thinking exercise which looks at the risk the registrant's nursing practice poses in the future. She referred the panel to the approach of Silber J in the case of *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) by asking the questions whether the concern is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

Ms Churaman referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). She referred the panel to the test formulated By Dame Janet Smith in the *Fifth Shipman Report,* quoted in the case of *Grant* which provides:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

Ms Churaman submitted that limbs a, b and c of the *Grant* test are engaged in this case.

With regards to limb a of the *Grant* test, Ms Churaman submitted that Mrs Svetlinska's failings in ensuring the provision of fundamental aspects of care to residents, failings in record-keeping and failings in taking action to avoid further harm to residents, placed residents at the Home at unwarranted risk of harm. She submitted that although Mrs Svetlinska was informed about such failings, she failed to take relevant steps to address the concerns which suggests a real risk of repetition.

With respect to limb b of the *Grant* test, Ms Churaman submitted that Mrs Svetlinska's failings brought the nursing profession into disrepute as they were not isolated incidents but occurred on several occasions.

In relation to limb c of the *Grant* test, Ms Churaman submitted that Mrs Svetlinska's areas of failings were in fundamental aspects of nursing profession especially as she served in dual capacities of registered manager and nurse at the Home. She submitted that Mrs Svetlinska therefore breached fundamental tenets of the nursing profession.

In conclusion, Ms Churaman submitted that Mrs Svetlinska's fitness to practise is currently impaired on the grounds of public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 *treat people with kindness, respect and compassion*

1.2 *make sure you deliver the fundamentals of care effectively*

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

To achieve this, you must:

3.1 *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

8 Work cooperatively

To achieve this, you must:

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

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.1 *provide honest, accurate and constructive feedback to colleagues*

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

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

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

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

To achieve this, you must:

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 *act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

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

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:

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

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

The panel took into account that Mrs Svetlinska performed dual roles at the Home, acting as the registered manager and also a nurse on duty. Mrs Svetlinska had the responsibility for the day-to-day management of the Home including activities of the staff and daily care of the residents. It was of the view that in Mrs Svetlinska's capacity as the registered manager, it was her responsibility to carry out day-to-day observations of activities of staff at the Home to ensure that staff performed their duties effectively in the delivery of fundamentals of care to the residents. It was also Mrs Svetlinska's responsibility as a nurse on duty to deliver such care to the residents in accordance with their respective care plans.

The panel was of the view that Mrs Svetlinska's failings in performing her responsibilities as the registered manager and a nurse on duty, placed residents at the Home at significant risk of harm. The panel considered Mrs Svetlinska's conduct amounted to a dereliction of her nursing duties and fell short of the fundamental obligations that registered nurses are expected to perform to residents under their care. It also amounted to a failure in Mrs Svetlinska's leadership to ensure residents' wellbeing was protected and that staff delivered fundamental aspects of care to residents.

Accordingly, the panel determined that Mrs Svetlinska's actions in charges 1b, 1e, 1f, 1g, 1j, and 1k amount to misconduct.

With respect to charges 2a and 2b, the panel considered accurate record-keeping as one of the fundamental tenets of the nursing profession. It was of the view that Mrs Svetlinska's failure to ensure that residents' records were accurately completed without falsification, posed a significant risk of harm to residents at the Home. It noted that her conduct could have deprived residents from receiving the relevant care they required in accordance with their care plans.

The panel considered Mrs Svetlinska's conduct to be a breach of her fundamental duty of care to residents and also constitutes a breach of the duty of candour to the residents and their families. Accordingly, the panel determined that Mrs Svetlinska's conduct in charges 2a and 2b amount to misconduct.

With regards to charge 4d, the panel considered Mrs Svetlinska's conduct to be unacceptable and that it fell short of the standard of nursing care expected from a registered nurse. It was of the view that Mrs Svetlinska's conduct placed the resident at risk of further harm and amounted to a breach of the fundamental duty of care to such resident. Accordingly, the panel determined that Mrs Svetlinska's conduct in charge 4d amount to misconduct.

Consequently, having considered the proven charges individually and as a whole, the panel determined that Mrs Svetlinska'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 Svetlinska's fitness to practise is currently impaired.

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act

with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *…..'*

The panel found that limbs a, b and c of the Grant test are engaged in this case. At the time of the incident, Mrs Svetlinska's misconduct placed residents at unwarranted risk of harm, brought the nursing profession into disrepute and breached fundamental tenets of the nursing profession, relating to adequate residents' care.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

> '*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

The panel is aware that this is a forward-looking exercise and accordingly, it went on to consider whether Mrs Svetlinska's misconduct is remediable and whether she had strengthened her nursing practice.

Regarding insight, the panel was of the view that Mrs Svetlinska has failed to show insight into her conduct. It noted that Mrs Svetlinska has failed to demonstrate insight on the impact of her conduct on residents at the Home, her colleagues and the nursing profession. The panel was concerned that Mrs Svetlinska did not demonstrate any understanding of the seriousness of her failings. Mrs Svetlinska did not provide any information about any detailed steps she would take if similar scenarios should occur in future or to prevent such situation in future.

The panel had regard to the case of *Cohen v GMC,* where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*
b. *Has it in fact been remedied?*
c. *Is it highly unlikely to be repeated?'*

The panel was of the view that Mrs Svetlinska's misconduct was generally capable of remediation. However, it noted that there was no evidence before it to indicate that Mrs Svetlinska had strengthened her nursing practice in the areas of concern. Mrs Svetlinska has not provided any evidence of training nor testimonials to demonstrate any positive steps she had taken to remediate her failings and strengthen her nursing practice.

In light of this, this panel determined that there is a real risk of repetition of Mrs Svetlinska's failings and therefore concluded that a finding of impairment is necessary on the grounds of public protection.

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

The panel had regard to the serious nature of Mrs Svetlinska's failings and determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case. It was of the view that a fully informed member of the public, aware of the proven charges in this case and her failure to strengthen her nursing practice, would be very concerned if Mrs Svetlinska were permitted to practise as a registered nurse without restrictions. For this reason, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold the proper professional standards for members of the nursing profession.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of twelve months. The effect of this order is that Mrs Svetlinska's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

Submissions on sanction

Ms Churaman submitted that the aggravating factors in this case are as follows:

- Several instances of poor care towards residents
- Inaccurate record-keeping
- Several instances of failure to remediate the concerns despite being notified by the CQC.

Ms Churaman referred the panel to the NMC Guidance on Seriousness which outlines the factors that indicate the seriousness of a case. She submitted that this case falls under '*Serious concerns which could result in harm to patients if not put right'*. Ms Churaman asserted that Mrs Svetlinska's failings placed residents at the Home at significant risk of harm. She submitted that although Mrs Svetlinska's failings were serious, they were capable of remediation.

Ms Churaman submitted that given the panel's findings on misconduct and impairment, taking no further action would not be appropriate in this case due to the seriousness of the concerns.

Ms Churaman submitted that a caution order would not be appropriate in this case as the panel had found that there is a risk of repetition and that Mrs Svetlinska's

misconduct poses a risk of harm to the public. She submitted that this case is not at the lower end of the spectrum of impaired fitness to practise and therefore, a caution order would not be proportionate in this case.

Ms Churaman submitted that a conditions of practice order is the appropriate and proportionate sanction in the circumstances of this case to protect the public and meet the public interest. She referred the panel to the SG on Conditions of practice order which states:

> *'Conditions of practice keep patients safe by addressing the concerns that led to the panel deciding the nurse, midwife or nursing associate's fitness to practise is currently impaired, but also allow the nurse, midwife or nursing associate to continue to work.'*
>
> *'Conditions may be appropriate when some or all of the following factors are apparent:*
>
> - *no evidence of harmful deep-seated personality or attitudinal problems;*
> - *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
> - *……..;*
> - *potential and willingness to respond positively to retraining;*
> - *……..;*
> - *patients will not be put in danger either directly or indirectly as a result of the conditions;*
> - *the conditions will protect patients during the period they are in force; and*
> - *conditions can be created that can be monitored and assessed.'*

Ms Churaman submitted that these factors are present in this case and therefore demonstrates that a conditions of practice order is the most appropriate sanction in the circumstances of this case.

The panel asked Ms Churaman whether there is an existing interim order on Mrs Svetlinska's nursing practice and whether she has been engaging with the NMC interim order proceedings.

Ms Churaman informed the panel that there is an existing interim conditions of practice order on Mrs Svetlinska's nursing practice which was last reviewed and varied on 23 November 2023. She stated that Mrs Svetlinska has not been engaging with the NMC interim order proceedings.

Decision and reasons on sanction

Having found Mrs Svetlinska'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:

- Wide range of failings in fundamental aspects of nursing practice
- Several instances of failure to remediate the concerns despite being notified by the CQC
- Mrs Svetlinska's failings placed residents at significant risk of harm
- No evidence of insight and remorse
- No evidence of remediation

The panel also took into account the following mitigating feature:

- Oral evidence from witness 1 that Mrs Svetlinska was working under undue pressure at the time of the incident.

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

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

The panel next considered whether placing conditions of practice on Mrs Svetlinska's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

> *'Conditions may be appropriate when some or all of the following factors are apparent:*
>
> - *no evidence of harmful deep-seated personality or attitudinal problems;*
> - *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
> - *……..;*
> - *potential and willingness to respond positively to retraining;*
> - *……..;*
> - *patients will not be put in danger either directly or indirectly as a result of the conditions;*
> - *the conditions will protect patients during the period they are in force; and*
> - *conditions can be created that can be monitored and assessed.'*

The panel noted that there was no evidence of deep-seated attitudinal concerns in this case. It was of the view that the concerns identified in this case could be addressed through retraining, robust supervision and assessment of Mrs Svetlinska's nursing practice.

Given the risks that have been identified and the context of the concerns, the panel was satisfied that the risks can be addressed and mitigated with a conditions of practice order. The panel determined that it would be possible to formulate appropriate and workable conditions which would address the failings highlighted in this case and which would protect the public and meet the public interest, while supporting Mrs Svetlinska's return to nursing practice.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of this case. It was of the view that the concerns could be addressed by a conditions of practice order and that it would be unduly punitive in the circumstances of this case to impose a suspension order or a striking-off order.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> 'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must not practice as the nurse in charge.

2. At any time that you are employed or otherwise providing nursing services, you must place yourself and remain under the supervision of a workplace line manager, mentor or supervisor nominated by your employer, such supervision to consist of working at all times on the same shift as, but not necessarily under the direct observation of, a registered nurse who is physically present in or on the same ward, unit, floor or home that you are working in or on.

3. You must work with your line manager, mentor or supervisor (or their nominated deputy) to create a personal development plan designed to address the concerns about the following areas of your practice:
   a) Record keeping;
   b) Safeguarding (including your responsibilities under the Deprivation of Liberty Standards and the Mental Capacity Act);
   c) Escalation of concerns;
   d) Communication within a multi-disciplinary team;
   e) Upholding dignity and treating patients with respect;
   f) Management of wound care and pressure sores;
   g) Pain management.

4. You must meet with your line manager, mentor or supervisor (or their nominated deputy) at least every month to discuss the standard of your performance and your progress towards achieving the aims set out in your personal development plan.

5. You must send a report from your line manager, mentor or supervisor (or their nominated deputy) setting out the

standard of your performance and your progress towards achieving the aims set out in your personal development plan to the NMC before any NMC review hearing or meeting.

6. You must tell the NMC within seven days of any nursing appointment (whether paid or unpaid) you accept within the UK or elsewhere and provide the NMC with contact details of your employer.

7. You must tell the NMC about any professional investigation started against you and/or any professional disciplinary proceedings taken against you within seven days of you receiving notice of them.

8. You must within seven days of accepting any post or employment requiring registration with the NMC, or any course of study connected with nursing or midwifery, provide the NMC with the name/contact details of the individual or organisation offering the post, employment or course of study.

9. You must within seven days of entering into any arrangements required by these conditions of practice provide the NMC with the name and contact details of the individual/organisation with whom you have entered into the arrangement.

10. You must immediately tell the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures, and disclose these conditions to them:
    a) Any organisation or person employing, contracting with, or using you to undertake nursing work;

b) any agency you are registered with or apply to be registered with (at the time of application) to provide nursing services;
c) any prospective employer (at the time of application) where you are applying for any nursing appointment; and
d) any educational establishment at which you are undertaking a course of study connected with nursing or midwifery, or any such establishment to which you apply to take such a course (at the time of application).

The panel decided to impose this order for a period of twelve months.

Before the order expires, a panel will hold a review hearing to see how well Mrs Svetlinska has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- A reflective piece from Mrs Svetlinska, demonstrating insight into the concerns and the panel's findings;
- Any references or testimonials attesting to Mrs Svetlinska's capability to perform her duties in any paid or unpaid work;
- Evidence of any training for professional development including certificates in the areas of concern;
- Any information as to Mrs Svetlinska's future nursing career plans; and
- Mrs Svetlinska's engagement and attendance at any future review hearing.

Interim order

As the conditions of practice 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 Svetlinska's own interests until the conditions of practice sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Churaman. She submitted that given that the panel has determined that a conditions of practice order is appropriate and proportionate, an interim order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period. She submitted that as the panel had determined that Mrs Sventlinska's failings pose a risk to the public and there is a real risk of repetition, an interim conditions of practice order is necessary on the same terms as the substantive conditions of practice order, to protect the public and meet the public interest in this case.

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

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the

substantive order for a period of 18 months in order to protect the public and otherwise in the public interest, during any potential appeal period.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Svetlinska is sent the decision of this hearing in writing.

This will be confirmed to Mrs Svetlinska in writing.

That concludes this determination.