Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 6 February 2023 – Monday, 13 February 2023
Tuesday, 21 March 2023
Tuesday, 23 May 2023
Monday, 17 July 2023 – Tuesday, 18 July 2023

Virtual Hearing

Name of Registrant:	**Vanessa Anne Platt**
NMC PIN	08A0046E
Part(s) of the register:	Registered Nurse - Adult - 7 September 2008
Relevant Location:	Wrexham
Type of case:	Misconduct
Panel members:	Paul O'Connor (Chair, lay member) Donna Green (Registrant member) Caroline Taylor (Lay member)
Legal Assessor:	Monica Daley (6-13 February 2023, 21 March 2023 and 17-18 July 2023) William Hoskins (23 May 2023)
Hearings Coordinator:	Clara Federizo (6-13 February 2023, 23 May 2023 and 17 July 2023) Sophie Cubillo-Barsi (21 March 2023) Margia Patwary (18 July 2023)
Nursing and Midwifery Council:	Represented by Maeve Thornton, Case Presenter
Mrs Platt:	Present in part (8 February 2023) and unrepresented 21 March 2023 – Not present and unrepresented 23 May 2023 – Not present and unrepresented 17 July 2023 – Not present and unrepresented

Facts proved:	Charges 1a, 1c, 1d, 2, 5, 7, 8, 9, 10, 11, 12, 13, 14, 16a-16b, 17, 18a-18c, 19a-19e, 20, 23, 26 and 32.
Facts not proved:	Charges 1b, 1e, 3, 4, 6, 15, 21, 22, 24a-24d, 25a-25c, 27, 28, 29, 30 and 31.
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 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 Platt was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 4 January 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Platt'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 Platt had been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in Mrs Platt's absence

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

Ms Thornton referred the panel to the e-mail correspondence from Mrs Platt, dated 3 February 2023, which states:

…"[PRIVATE]"…

In light of the information above, Ms Thornton submitted that Mrs Platt had voluntarily absented herself. Ms Thornton further submitted that there is a strong public interest for the case to proceed in Mrs Platt's absence, given the history of postponement of this matter, and drew the panel's attention to her written response to the regulatory concerns on 29 May 2018.

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.

The panel decided to proceed in Mrs Platt's absence. In reaching this decision, the panel has considered the submissions of Ms Thornton, Mrs Platt's e-mail regarding attendance, and the advice of the legal assessor. It 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:

- There was no application made by Mrs Platt for an adjournment;
- Mrs Platt informed the NMC that she received the Notice of Hearing, by way of e-mail correspondence, and consequently voluntarily absented herself;
- There is no reason to suppose that adjourning would secure Mrs Platt's attendance at some future date;
- Witnesses were intending to give live evidence;
- 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 Platt in proceeding in her absence. Although the evidence upon which the NMC relies will have been previously sent to her by e-mail address, Mrs Platt will not be able to challenge the evidence relied upon by the NMC 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, Mrs Platt had indicated that she may be contacted by phone during the proceedings should the panel deem this necessary.

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

Details of charge

That you, a registered nurse acting as Home Manager of Stansty House Nursing Home, between May 2017 to October 2017:

1. Failed to ensure that residents files contained the following:
    a) pre-admission assessments **[PROVED]**
    b) end of life planning **[NOT PROVED]**
    c) updated body maps **[PROVED]**
    d) inventory of client belongings **[PROVED]**
    e) care plans **[NOT PROVED]**

2. Failed to ensure that residents had sufficient food and fluid intake. **[PROVED]**

3. Failed to ensure that resident's received warm food. **[NOT PROVED]**

4. Failed to ensure that patients received drinking water. **[NOT PROVED]**

5. Failed to ensure that an unnamed resident received his nutritional supplement three times a day. **[PROVED]**

6. Failed to ensure that the Home was adequately staffed. **[NOT PROVED]**

7. Failed to ensure that residents identified as at risk of malnutrition were weighed monthly. **[PROVED]**

8. Failed to ensure that nutritional care plans for residents were reviewed between June 2017 to October 2017. **[PROVED]**

9. Failed to ensure that residents care plans were properly audited. **[PROVED]**

10. Failed to ensure that assessments for residents at risk of pressure ulcers were updated monthly. **[PROVED]**

11. Failed to ensure that air mattresses for residents were set up correctly. **[PROVED]**

12. Failed to ensure that residents were repositioned regularly to avoid tissue damage. **[PROVED]**

13. Failed to ensure that residents care plans were reviewed on a monthly basis. **[PROVED]**

14. Failed to make referrals to professionals for residents when needed. **[PROVED]**

15. Failed to ensure that medication audits were carried out on a weekly basis. **[NOT PROVED]**

16. Failed to ensure that adequate instructions were provided for staff on how to administer medication for residents on the:
    a) care plan and/or **[PROVED]**
    b) medication sheet **[PROVED]**

17. Failed to ensure that adequate systems were in place to monitor the Home's management. **[PROVED]**

18. Failed to ensure the Home had an adequate handover sheet to record the following information:
    a) How often a patient should be repositioned **[PROVED]**
    b) Specific medical care for residents **[PROVED]**
    c) DNAR statuses **[PROVED]**

19. Failed to ensure that agency staff were given full information on:
    a) specific patients care needs **[PROVED]**
    b) policy and procedure **[PROVED]**
    c) where equipment was located **[PROVED]**
    d) tour of the Home **[PROVED]**
    e) role and/or responsibilities **[PROVED]**

20. Failed to escalate safeguarding concerns to the Inspectorate and/or the local safeguarding authority. **[PROVED]**

21. Failed to ensure that regular management meetings were held with the Unit managers at least every 3 or 4 months. **[NOT PROVED]**

22. Failed to ensure that staff received adequate training. **[NOT PROVED]**

23. Failed to ensure that unit managers received supervision. **[PROVED]**

24. In relation to resident 1 between 7th August 2017 – 19th August 2017, failed to ensure that:
    a) she received gluten free meals **[NOT PROVED]**
    b) received her medication on time **[NOT PROVED]**
    c) received hot drinks **[NOT PROVED]**
    d) was cleaned in a timely manner **[NOT PROVED]**

25. In relation to resident 2, failed to ensure that:
    a) his bed was suitable and/or in good condition **[NOT PROVED]**
    b) his wound dressings were changed regularly **[NOT PROVED]**
    c) a care plan for repositioning was put in place **[NOT PROVED]**

26. Failed to ensure staff answered call bells in a timely manner. **[PROVED]**

27. Failed to ensure that residents were bathed regularly. **[NOT PROVED]**
28. Failed to ensure that colleague 1 was informed that a patient who suffered from Huntingdon's disease required feeding by a nurse. **[NOT PROVED]**

29. Failed to ensure that residents had beds suitable for their needs. **[NOT PROVED]**

30. Failed to ensure that residents wounds were cleaned on a regular basis. **[NOT PROVED]**

31. Failed to ensure that an unnamed resident was given liquidated food. **[NOT PROVED]**

32. Failed to ensure that staff were given breaks. **[PROVED]**

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

Decision and reasons on application to adduce hearsay evidence

The panel heard an application made by Ms Thornton under Rule 31 to allow the written statement of Mr 5 into evidence. Mr 5 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, they were unable to attend due to personal reasons.

Ms Thornton submitted that the evidence is highly relevant and placed before panel. The evidence referred to is a written statement previously signed and dated by Mr 5. Ms Thornton referred the panel to relevant case law and submitted that this is not the sole and decisive evidence available, and it is corroborated by exhibits and other witness statements, namely that of Ms 3.

In the preparation of this hearing, the NMC had indicated to you in the Case Management Form (CMF) that it was the NMC's intention for Mr 5 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Mr 5, you made the decision not to attend this hearing. On this basis Ms Thornton advanced the argument that there was no lack of fairness to you in allowing Mr 5's written statement into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application, as well as the relevant case law, namely *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565, *NMC v Ogbonna* [2010] EWCA Civ 126*, R (Bonhoeffer) v GMC* [2011] EWHC 1585 and *El Karout v NMC* [2019] EWHC 28. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application, in regard to Mr 5, consideration and bore in mind the test of relevance and fairness in reaching its decision. The panel had particular regard to the guidance set *out at paragraph 56 of Thorneycroft,* which states:

“56. The decision to admit the witness statements despite their absence required the Panel to perform careful balancing exercise. In my judgment, it was essential in the context of the present case for the Panel to take the following matters into account:

(i) whether the statements were the sole or decisive evidence in support of the charges;
(ii) the nature and extent of the challenge to the contents of the statements;
(iii) whether there was any suggestion that the witnesses had reasons to fabricate their allegations;
(iv) the seriousness of the charge, taking into account the impact which adverse findings might have on the Appellant's career;
(v) whether there was a good reason for the non-attendance of the witnesses;
(vi) whether the Respondent had taken reasonable steps to secure their attendance; and
(vi) the fact that the Appellant did not have prior notice that the witness statements were to be read.”

The panel determined that the written statement of Mr 5 is relevant as it covers the dates within the charges and particularly relate to the time that Ms 3 was working in the Home. The panel accepted that the evidence of Mr 5 was not the sole and decisive evidence in relation to charges 19b, c and d as this was also corroborated in the live witness evidence of Ms 3. Further, the panel considered that the evidence in question provided additional information beyond the documentary information from an independent party. For these reasons, the panel determined that the relevance test had been met.

In terms of fairness, the panel considered whether Mrs Platt would be disadvantaged by the change in the NMC’s position of moving from reliance upon the live testimony of Mr 5 to that of a written statement into evidence. The panel acknowledged that Mr 5’s statement had been prepared in anticipation of being used in these proceedings and

contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and was signed by them on 17 August 2018. In light of this, the panel noted that you would have had the opportunity to read the bundle of documentation which includes Mr 5's written statement. The panel determined that Mrs Platt had reasonable time to contest or raise any commentary about the information held in the statement but has not done so. Therefore, the panel was satisfied that there is no underlying unfairness to the admission of Mr 5's written statement as hearsay evidence. It determined the fairness test had been met.

In considering the question of the weight which it should attribute to hearsay evidence, the panel had regard to the case of *El Karout v NMC* [2019] EWHC 28 and it will apply the relevant standard of proof when considering its decision on facts.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Mr 5 but would give what it deemed appropriate weight once the panel has heard and evaluated all the evidence before it.

Your attendance on 8 February 2023

After considering all the witness evidence, the panel noted that you mentioned in earlier correspondence regarding attendance that it was possible for you to answer questions from the panel by phone. The panel was of the view that there were reasonable adjustments that could be made to accommodate you.

Upon making contact, you confirmed you would attend and give live evidence under affirmation.

The panel heard evidence from you under oath. However, due to lack of time, the hearing was paused and due to continue the following day with cross-examination from the NMC.

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

During the course of the hearing the panel received an update from you on 9 February 2023, that due to personal reasons, you wished to make an application for a temporary adjournment. As the details of this request involved private matters, the panel considered that this hearing should be held partly in private in order to protect your privacy. The application was made pursuant to Rule 19.

Ms Thornton indicated that she did not oppose the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to move into private session as and when any private matters are considered, or such issues are raised in order to protect privacy and confidentiality in these matters.

Decision and reasons on application to adjourn the hearing

On 9 February 2023, the fourth day of the hearing, the NMC received correspondence from you regarding an urgent private matter which arose that impeded you from attending the arranged time for cross-examination. You requested to adjourn the continuation of your live evidence under oath to later in the week. Ms Thornton submitted that the NMC's position is neutral to your request to adjourn the hearing and that this is a matter for the panel to decide.

The panel heard the advice of the legal assessor.

The panel acknowledged the personal circumstances which were out of your control and your specific request to adjourn the hearing until 10 February 2023. The panel noted that you wish to continue to engage in the proceedings, and it is in the interest of fairness to you that the entirety of your evidence is heard. The panel also determined that it is in the interest of the public that there was opportunity for the NMC to cross-examine you and for you to continue to engage in the process. The panel determined that the hearing was to be adjourned until the following day, at which point, contact will be made with you in this regard.

The hearing was resumed on the morning of 10 February 2023

Ms Thornton provided the panel with an update in relation to your attendance following the previous adjournment. She submitted that the NMC case officer handling the case had made several attempts to contact you including an e-mail and a phone call which was not answered. A voicemail was left, and a text message was sent asking you to reply to previous e-mails and let the NMC know if you will attend. No response was received. Ms Thornton invited the panel to adjourn the hearing until 13 February 2023 to give you an opportunity to finish giving your live evidence as you have shown willingness to engage with the proceedings prior to your personal circumstances arising.

The panel heard the advice of the legal assessor.

The panel acknowledged that reasonable steps were taken by the NMC to secure your attendance at this hearing. The panel noted that it has had the opportunity to ask questions and receive a considerable amount of information from this. However, it was mindful that the element outstanding was the NMC cross-examination given that you have chosen to give evidence under oath. The panel considered all the information placed before it and noted that you have shown willingness to engage in the proceedings prior to the personal circumstances arising. The panel also noted that you have communicated you would be available to engage at this date. It also recognised that it is in the public interest and in the interest of fairness that the NMC has an opportunity to cross-examine

your evidence, given the weight that this evidence has in doing so under oath. Therefore, the panel determined to adjourn the hearing to give you an opportunity to respond.

The hearing was resumed on the morning of 13 February 2023

Decision and reasons on application to proceed in absence

Ms Thornton referred the panel to the e-mail correspondence received from you on 13 February 2023, which stated:

> *"…[PRIVATE]…*
>
> *I feel at this stage I can't do anything to support my case further other than the statement I wrote and firmly stand by. It's been almost 6 years and I suppose to remember everything that happened when I was there. If this case has gone to panel much sooner then things would be much clearer and fresher in my memory.*
>
> *I thank the panel for taking time to listen to me."*

In light of the above, Ms Thornton submitted that you voluntarily absented yourself from the hearing having been advised of the prior adjournments. She submitted that there is a strong public interest in the expeditious disposal of the case and invited the panel to proceed in your absence.

The panel heard the advice of the legal assessor.

The panel had regard to all the information and acknowledged your health and personal circumstances. However, the panel was mindful that you have been advised of the prior adjournments and given an opportunity to attend. Further, the panel considered that you have changed your stance in terms of your desire to participate and specified that you are

not intending to return to nursing. The panel concluded that you have demonstrated a settled position on non-attendance to the hearing.

In considering the public's interest for the expeditious disposal of the case, the panel determined to proceed in your absence. In this effect, you have also released yourself from oath.

Background

The charges arose whilst Mrs Platt was employed as a registered nurse acting as Home Manager of Stansty House Nursing Home (the Home), between May 2017 to October 2017.

On 16 October 2017, the Care Inspectorate Wales (CIW) conduct an unannounced visit to the home. The report highlighted a number of areas in need of improvement. On 19 December 2017, a second CIW inspection was carried out and positive improvements were identified. However, the report noted that there were still further developments to be made. The following headlines of concern were apparent from the October 2017 inspection:

- The Unit Manager had been off sick since May 2017 and Mrs Platt was effectively managing the nursing unit at the expense of carrying out managerial responsibilities;
- Care documentation was insufficient;
- There was a lack of auditing;
- Pressure ulcer assessments were not being updated regularly;
- Care plans were not being followed;
- The handover sheet was inadequate – it should have been identified by Mrs Platt that the document was not fit for purpose and rectified;
- Staffing concerns (overuse of agency staff and a lack of permanent qualified staff) which had a direct impact on the level of care being provided to the residents. This

overuse of agency staff was not in the best interests of residents as consistency and continuity of care was jeopardised; and

- Safeguarding issues had not been escalated/referrals had not been made (e.g. referrals to the tissue viability nurse).

On 12-15 January 2018, Mrs Platt was referred to the NMC in relation to areas of regulatory concern in managing nursing home effectively, placing residents at risk, namely:

- Failure to ensure residents' documentation is accurate and up to date;
- Lack of auditing;
- Failure to ensure residents' care needs are met and monitored across the units;
- Failure to ensure continuity of care to residents through excessive use of agency staff;
- Safeguarding issues not appropriately escalated; and
- Inadequate support and supervision of staff.

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 Thornton on behalf of the NMC.

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

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

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

- Ms 1: Formerly employed by the Care Inspectorate Wales as the Team Manager for the Registrations Team, Regulation Inspector at the time of the events;

- Ms 2: Contracts and Monitoring Officer at Wrexham County Borough Council since July 2016. Communicated with Mrs Platt in relation to issues and concerns raised at the Home;

- Ms 3: Registered Nurse, worked three days at the Home (as an Agency Nurse) at the time of the events. Contacted Safeguarding Wrexham and Care Inspectorate Wales (CSSIW) on 3 and 4 October 2017 to voice her concerns;

- Mr 4: Regional Manager for North Wales and Northwest England, Minster Care Group.

The panel also had regard to the witness statement of Mr 5, an agency nurse.

The panel heard evidence from you under oath.

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

In terms of accountability and responsibility, the panel noted that whilst there was not a job description signed by you placed before it, you were an experienced registered nurse and, on the balance of probabilities, you would have had access to a generic job description prior to attaining employment at the Home. The panel further noted that, according to Mr 4's oral evidence, you have been employed in similar roles beforehand. Considering these factors, the panel determined that you would have had an oversight of the responsibilities for the overall care of all residents within the Home to understand the circumstances and appropriate management within the nursing unit.

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

Charge 1a)

1) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents files contained the following:

    a) Pre-admission assessments"

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Mr 4 and Ms 2, the Quality Monitoring Framework & Report signed by Ms 2 dated 17 May 2017 and the report published in November 2017 (following an October 2017 visit). The panel also had regard to the Ongoing Monitoring Action Plan Updates dated 16 August 2017.

The panel determined that the oral evidence of Ms 2 and the reports prior to May 2017 substantiate that there were issues identified within the management of the Home prior to your employment. The panel considered that you were only accountable within a month

after your induction having had the opportunity to adjust into the role, and that the responsibility that would lie on you is whether appropriate progress was made since then. Despite the lack of pre-admission assessments prior to your employment at the Home, the panel found no evidence of sufficient progress made by October 2017. The action plan updates stated that:

> *"Pre-Admission Assessments are not always signed/dated, or in some cases do not exist. These must be completed in full and located in resident files in all cases."*

The panel noted that the pre-admission assessments were not checked during visit on 16 August 2017 but that, according to the report during the 13 December 2017 visit, no pre-admission assessments were in place. The panel found that, on the balance of probabilities, it is more likely than not that that the pre-admission assessments were not completed, and you, as the Home Manager, failed to ensure that residents files contained these.

The panel had taken into context the problems which existed with the management and staffing of the Home prior to you commencing your role as a manager. It considered that it was unlikely to be a priority to undertake a retrospective pre-admission assessment of previous residents. However, it considered that given the action plan reports, this was known to be a problem, and therefore it was your responsibility as the Home Manager between May 2017 to October 2017 to ensure this was completed for the new residents.

The panel therefore finds this charge proved.

Charge 1b)

1) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents files contained the following:

b) End of life planning”

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness evidence given by Ms 1 and Ms 2, the Quality Monitoring Framework & Reports and the Ongoing Monitoring Action Plan Updates dated 16 August 2017 and 13 December 2017.

The panel had regard to the information placed before it and considered that on the 16 August 2017 visit, resident files were reviewed in terms of End of Life information. Section 6 of the report stated:

> *“Of the 5 resident files reviewed during the visit on 16 August 2017, only 2 contained End of Life information”*

In the subsequent December 2017 audit, of the files which were checked, only one file was found to be missing end of life planning. On that basis, the panel determined that there is insufficient evidence to determine that more than one resident’s file failed to contain end of life planning.

The panel therefore finds this charge not proved.

Charge 1c)

1) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents files contained the following:

c) Updated body maps”

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence given by Ms 2, the Quality Monitoring Framework & Reports and the Ongoing Monitoring Action Plan Updates dated 16 August 2017 and 13 December 2017.

The panel had regard to the information placed before it and considered that in the 16 August 2017 visit, resident files were reviewed. Section 17 of the report stated:

> *"Of the 5 resident files reviewed during the visit on 16 August 2017, body maps were either not applicable, or one contained an injury from February 2017 which had not been signed off as resolved."*

Further, the panel had regard to the 13 December 2017 visit as a point of comparison. The December 2017 visit reported that the EMI Unit was signed off and that in the Residential Unit *"Body Maps are not being updated when injuries have healed"*. The panel noted that the Nursing Unit was not checked during the visit.

The panel concluded that, on the balance of probabilities, it was more likely than not that you, as the Home Manager of the Home between May 2017 and October 2017, failed to ensure that residents files contained updated body maps.

The panel therefore finds this charge proved.

Charge 1d)

1) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents files contained the following:

    d) Inventory of client belongings"

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence given by Ms 2, the Quality Monitoring Framework & Reports and the Ongoing Monitoring Action Plan Updates dated 16 August 2017 and 13 December 2017.

The panel had regard to the information placed before it and considered that in the 16 August 2017 visit, resident files were reviewed. Section 26 of the report stated:

> *"**Residential Unit:** Of the 2 files reviewed, no date was on 1 inventory, and 1 had not been updated since Aug 2016.*
> ***EMI Unit:** No inventory of belongings in the 2 files reviewed."*

The panel noted that the Nursing Unit was not checked.

Further, the panel had regard to the 13 December 2017 and 29 January 2018 visits as a point of comparison. Section 24 of the report stated:

> *"**Residential Unit:** Of the 2 files reviewed, no date was on 1 inventory, and 1 had not been updated since Aug 2016.*
> ***EMI Unit:** No inventory of belongings in the 2 files reviewed.*
> ***Nursing Unit:** No inventory of belongings in the 2 files reviewed."*

The panel concluded that, on the balance of probabilities, it was more likely than not that you, as the Home Manager of the Home between May 2017 and October 2017, failed to ensure that residents files contained an inventory of client belongings.

The panel therefore finds this charge proved.

Charge 1e)

1) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents files contained the following:

    e) Care plans”

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness evidence given by Ms 2 and Mr 4, the Quality Monitoring Framework & Reports and the Ongoing Monitoring Action Plan Updates and the evidence from the CIW, as well as your admission that the care plans were not up to date.

The panel found that there was evidence before it to suggest that care plans were in place. However, the panel noted that the care plans were not always up to date, and that this is a serious concern but this was not the charge before the panel. It had regard to the burden of proof and determined on the balance of probabilities that this charge was not proved.

The panel therefore finds this charge not proved.

Charge 2)

2) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents had sufficient food and fluid intake”

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Ms 1 and the Care Inspectorate Wales Report published on 22 November 2017. The report states:

*"**Our findings***

People unable to care for themselves independently are not always given the nutritional care they need. Care files showed nutritional assessments had not been updated, or in some cases completed. For example, people with specific medical needs such as impaired kidney function or changes with their swallowing had food and drink charts, but they were not consistently completed, or analysed by qualified staff in order to determine if the intake for individuals was sufficient to meet their needs. We found one person's recorded fluid intake was 110ml for a 24 hour period. Another chart showed one meal had been offered all day with no drinks recorded over a 24 hour period."

The panel had regard to the oral evidence of Ms 1 who testified to the lack of documentary evidence that shows residents were receiving the required food and fluid intake. The panel concluded that, on the balance of probabilities, it was more likely than not that you, as the Home Manager of the Home between May 2017 and October 2017, failed to ensure that residents had sufficient food and fluid intake.

The panel therefore finds this charge proved.

Charge 3)

3) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents received warm food"

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Mr 4 and Ms 2. The panel considered that Ms 2 referred to a complaint from one of the residents' relatives about the resident not receiving warm food. The panel contrasted this with the oral

evidence heard from Mr 4, where there was an indication that they changed their food supplier and the organisation of this.
The panel concluded that, on the balance of probabilities, it was more likely than not that this one-off issue stemmed from a systemic or procedural error as opposed to you, as the Home Manager of the Home between May 2017 and October 2017, failing to ensure that residents received warm food.

The panel therefore finds this charge not proved.

Charge 4)

4) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that patients received drinking water”

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Ms 1 and Ms 3.

The panel recognised that the evidence of Ms 1 and Ms 3 was reliable and credible, however, it determined to give less weight in relation to this charge. The panel was mindful that Ms 1’s oral testimony was not supported by documentary evidence but rather, on the balance of probability, was more likely an assumption derived from the incomplete fluid balance charts. Ms 3 had only worked at the Home for three days which was not sufficient evidence to satisfy the panel that you failed to ensure that patients received drinking water over the six-month period of your employment. Further, the panel noted that Mr 4 monitored issues within the Home on a regular basis but did not raise issue in relation to this charge.

The panel concluded that there was insufficient evidence placed before the panel to satisfy that you, as the Home Manager of the Home between May 2017 and October 2017, failed to ensure that patients received drinking water.

The panel therefore finds this charge not proved.

Charge 5)

5) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that an unnamed resident received his nutritional supplement three times a day”

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Ms 1 which set out the particular incident with a resident, the CIW audit report dated 31 January 2018 in support of this and the job description for the role of Home Manager.

The panel was of the view that, as a Home Manager, you had a responsibility of prioritising residents and ensuring that there were systems in place for all care staff to record nutritional information accurately, in order to enable key data to be captured and acted on. In this particular instance, there are examples of spot checks where the correct nutritional supplement was not given or at least not recorded as being given.
The panel concluded that, on the balance of probabilities, it was more likely than not that you, as the Home Manager of the Home between May 2017 and October 2017, failed to ensure that an unnamed resident received his nutritional supplement three times a day.

The panel therefore finds this charge proved.

Charge 6)

6) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that the Home was adequately staffed”

This charge is found NOT proved.

In reaching this decision, the panel took into account the oral evidence of Ms 2, Ms 3, Mr 4 and Mr 5.

The panel had regard to Mr 4’s oral evidence who indicated that there was adequate staffing at the time of the events and that assessments were carried out to determine the level of staff required.

The panel noted that Mr 5 and Ms 3 indicated that the Home was busy but neither explicitly stated that staffing was inadequate. The witnesses indicated to the panel that the Home employed a lot of Agency nurses, and the panel was of the view that there is no information to suggest that Agency staff were ‘inadequate’.

Further, Mr 4 told the panel that recruiting was a difficult process to undertake, but the panel was of the view that this was not a fault that can be attributed to failings as a Home Manager.

The panel concluded that there was insufficient information placed before it to satisfy that you, as the Home Manager of the Home between May 2017 and October 2017, failed to ensure that the Home was adequately staffed.

The panel therefore finds this charge not proved.

Charge 7)

7) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents identified as at risk of malnutrition were weighed monthly”

This charge is found proved.

In reaching this decision, the panel took into account the Quality Monitoring Framework & Reports and Action Plan Updates dated 16 August 2017 and 13 December 2017, as well as the witness evidence given by Ms 3.

The panel had regard to the information placed before it and considered that in the 16 August 2017 visit, resident files were reviewed. Section 18 of the report stated:

> *“Of the 5 resident files reviewed during the visit on 16 August 2017, 2 weights were recorded monthly, 2 were partially completed (not each month), and 1 was not applicable as a new resident.”*

Further, the panel had regard to the 13 December 2017 and 29 January 2018 visits as a point of comparison. Section 17 of the report stated:

> *“**Residential Unit:** 1 file is correct; 1 file states weights are to be completed on the 1st of every month but are being done on the 17th, weights are also switch from stone to kg, and November's weight is not in the file.*
> ***EMI Unit:** 2 files contain all weights, however 1 file only contains months, and not specific dates.”*

The panel also had regard to the witness evidence given by Ms 3, which is consistent and corroborates the information on the report. The panel concluded that, on the balance of probabilities, it was more likely than not that you, as the Home Manager of the Home between May 2017 and October 2017, failed to ensure that residents identified as at risk of malnutrition were weighed monthly.

The panel therefore finds this charge proved.

Charge 8)

8) “That you, a registered nurse, failed to ensure that nutritional care plans for residents were reviewed between June 2017 to October 2017”

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Ms 1 and Ms 3 as well as the CIW report. The CIW report, dated 22 November 2017, stated:

> *“…Two people, assessed as at risk of malnutrition, had nutritional care plans which stated they were to be weighed monthly. We found this had not been done for one person since June 2017 and the other since July 2017, both had suffered from significant weight loss in this time. Record also showed nutritional care plans had not been reviewed since they were written in June 2017. People are not as healthy as they could be and may be at risk of harm. …”*

The panel also had regard to the oral evidence of Ms 1, which highlights that the nutritional care plans were not reviewed, and this was supported by the oral evidence of Ms 3 as she told the panel that she was not able to find the appropriate care plans. The panel found this witness evidence to be clear, consistent and credible.
The panel concluded that, on the balance of probabilities, it was more likely than not that you, a registered nurse, failed to ensure that nutritional care plans for residents were reviewed between June 2017 to October 2017.

The panel therefore finds this charge proved.

Charge 9)

9) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents care plans were properly audited”

This charge is found proved.

In reaching this decision, the panel took into account the CIW report, Ms 2’s investigations report, her witness evidence and that of Ms 1 and Mr 4.

The panel had regard to the witness evidence and found that Ms 2’s testimony was clear and consistent with her investigation report in relation to whether the care plans were properly audited. The evidence of Ms 1 and Mr 4 support that the care plans were not being properly audited. Further, the panel noted that you have also admitted that the residents’ care plans were not audited on regular basis because there was a focus on writing the revised care plans for all residents.

The panel concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents care plans were properly audited.

The panel therefore finds this charge proved.

Charge 10)

10) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that assessments for residents at risk of pressure ulcers were updated monthly”

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Ms 1 and the CIW report which supports this.

The panel had regard to the findings on the CIW report, dated 22 November 2017, which states:

> *"…We saw one person had been seen by the Tissue Viability Nurse (TVN) and recommendations had been made, but the care plan was not updated until 19 days later. As a result of TVN visit CSSIW were made aware the pressure ulcers were of such a nature that referrals to the Local Authority Safeguarding team had been made. Pressure management plans had been written for two people in June 2017 but not reviewed since then..."*

The panel found the oral evidence of Ms 1 in relation to this was clear, credible and consistent with the findings outlined on the CIW report set out above.

The panel concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that assessments for residents at risk of pressure ulcers were updated monthly.

The panel therefore finds this charge proved.

Charge 11)

11) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that air mattresses for residents were set up correctly"

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Ms 1 and the CIW report which supports this.

The panel had regard to the findings on the CIW report, dated 22 November 2017, which states:

> *"…We found air mattresses were in place to minimise the risk of pressure ulcers, but two mattresses were set to very high setting which did not correlate to people's weight who were using them. Incorrect use of equipment can add pressure to already vulnerable skin…"*

The panel found the oral evidence of Ms 1 in relation to this was clear, credible and consistent with the findings outlined on the CIW report set out above.

The panel concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that air mattresses for residents were set up correctly.

The panel therefore finds this charge proved.

Charge 12)

12) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents were repositioned regularly to avoid tissue damage"

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Ms 1 and Ms 3, as well as the CIW report which supports this.

The panel had regard to the findings on the CIW report, dated 22 November 2017, which states:

> *"…The care charts of one individual assessed as at high risk of developing pressure ulcers showed they were attended to regularly by care staff. The chart indicated the person should be assisted to change position in order to relieve pressure. However, records completed by staff showed the person was "sat in bed" in the same position for several hours. It is essential that people who are at risk of developing pressure ulcers move position at regular intervals. Failure to do this will significantly increase their likelihood to develop pressure wounds and negatively impact on their health and well-being."*

The panel found the oral evidence of Ms 1 in relation to this was clear and consistent with the findings outlined on the CIW report set out above, and also corroborated by the witness evidence of Ms 3, in relation to the resident with a wound who was not being turned regularly.

The panel concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents were repositioned regularly to avoid tissue damage.

The panel therefore finds this charge proved.

Charge 13)

13) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents care plans were reviewed on a monthly basis"

This charge is found proved.

In reaching this decision, the panel took into account the non-compliance notice form, completed on 14 December 2017, which states:

> *"The registered person is not compliant with Regulation 15 (2) (c) (d). This is because care plans have not been reviewed and revised as appropriate and do not reflect the up to date needs of people."*

The panel also had regard to the local authority safeguarding team referral, which arose because of the pressure sores for the particular resident, as well as the witness evidence. The panel found the oral evidence of Ms 1 in relation to this was clear, consistent and credible, which was corroborated by the witness evidence of Ms 3.

The panel concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents care plans were reviewed on a monthly basis.

The panel therefore finds this charge proved.

Charge 14)

14) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to make referrals to professionals for residents when needed"

This charge is found proved.

In reaching this decision, the panel took into account the non-compliance notice form, completed on 14 December 2017, which states:

> *"We reviewed care records and found people had suffered with pressure ulcers which had necessitated treatment in hospital, significant unintentional weight loss*

and an injury sustained during manual handling by staff. CSSIW had not been notified by the home of any of the incidents. The acting manager was unaware referrals had been made to the local authority by another staff member. Incident and reporting forms are not collated or analysed to identify patterns and potential practice issues."

The panel also had regard to the oral evidence of Mr 4, who raised this and informed the panel of other dietitian referrals. The panel was of the view that, in your role, you failed to ensure that there were systems in place to know about these referrals. The panel concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to make referrals to professionals for residents when needed.

The panel therefore finds this charge proved.

Charge 15)

15) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that medication audits were carried out on a weekly basis"

This charge is found NOT proved.

In reaching this decision, the panel took into account Ms 2's investigations audit report, as well as Mr 4's oral evidence in support of this. The panel had regard to the information before it and recognised that, according to the report on 16 August 2017, the MAR charts needed to be urgently reviewed and audited as there were concerns regarding the completion and accuracy of these. Following this, the position was that you informed Ms 2 that the MAR charts were being double checked. The next visit was on 13 December 2017. On this visit it appears that no medication audit was carried out. In light of this, the panel had no evidence before it on which it can be satisfied, on the balance of

probabilities, that between May 2017 to October 2017, you failed to ensure that medication audits were carried out on a weekly basis.

The panel was of the view that there was insufficient evidence before it to know how often the medication audits should be done or that they had not been carried out on a weekly basis.

The panel therefore finds this charge not proved.

Charge 16a)

16) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that adequate instructions were provided for staff on how to administer medication for residents on the:

a) Care plan"

This charge is found proved.

In reaching this decision, the panel took into account the non-compliance notice form, completed on 14 December 2017, which states:

"…An individual who required to be given nutrition through a Percutaneous endoscopic gastrostomy (PEG) tube was not being given the prescribed amount. A dietician report dated June 2017 prescribed 250mls of a supplement 4x daily and 200mls at night. The regime was documented in their care plan but the amounts and times were not included. These were hand written on the care charts. However the amounts were reviewed by a dietician in August 2017 and the amount was reduced to 200mls x5 daily due to deterioration in the person's condition. This had

not been reflected in either the care plan or care charts. The records we viewed 15 showed that the incorrect amounts had been given…

…An agency nurse we spoke with did not know about the specific instructions required when administering medication to the individual…"

The panel also had regard to the oral evidence of Mr 5, who outlined the events on 29 September 2017 during the handover. Mr 5 set out that the Agency nurses were not given a tour or induction, nor did they receive clear instructions or the usual information given in a handover, such as who the percutaneous endoscopic gastrostomy ('PEG') feed residents are, the 'do's and don'ts' and any residents' doctor visits. Therefore, the Agency nurses, on that day, were not provided with sufficient information as to how to administer medication for residents on the care plan.

The panel found the evidence of Mr 5 to be consistent with the evidence on Ms 1's non-compliance report. The panel therefore concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that adequate instructions were provided for staff on how to administer medication for residents on the care plans.

The panel therefore finds this charge proved.

Charge 16b)

16) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that adequate instructions were provided for staff on how to administer medication for residents on the:
    b) Medication sheet"

This charge is found proved.

In reaching this decision, the panel took into account the non-compliance notice form, completed on 14 December 2017, which states:

> *"Due to swallowing difficulties it was agreed that covert medication in the form of tablets being crushed to assist with swallowing was to be given.. A note from the GP in relation to this was dated 09.05.17 was filed next to the MARR chart. On 15.10.17 nurse notes written on MARR chart stated; "unable to swallow this big tablet….. chewing on it…. despite many attempts to get her to swallow". This action could have resulted in the person choking and being distressed. There was no information in the care file to inform staff medicines were to be administered covertly and MARR front sheet did not indicate this either (this section was left blank). An agency nurse we spoke with did not know about the specific instructions required when administering medication to the individual."* [sic]

The panel also had regard to the oral evidence of Mr 5, who outlined the events on 29 September 2017 during the handover. Mr 5 set out that the Agency nurses were not given a tour or induction, nor received clear instructions or the usual information given in a handover, such as who the PEG feed residents are, the 'do's and don'ts' and any residents' doctor visits. He told the panel that the Agency nurses, on that day, did not know where or how to access the medication sheets.

The panel found the evidence of Mr 5 to be consistent with the evidence on Ms 1's non-compliance report. The panel therefore concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that adequate instructions were provided for staff on how to administer medication for residents on the medication sheet.

The panel therefore finds this charge proved.

Charge 17)

17) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that adequate systems were in place to monitor the Home’s management”

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Ms 1, dated 25 February 2019, which sets out:

> *“…Every home runs differently; not all homes have unit managers. Our expectation is that whatever the system Stansty had in place, the manager of the home would have some oversight of what was happening and it would be up to them as to how to delegate this, but they should be able to demonstrate how they check that things are being done. We couldn’t see any systems like that in place at the time of the October inspection. It appeared due to the absence of the Unit Manager, the registrant’s time was focussed on running the nursing unit rather than overseeing the home. I would have expected a home manager, if they didn’t have something in place within four months, then they should have a plan for what they would put in place but with the Unit Manager not being in to manage the nursing unit, most of the registrant’s time seemed to be spent on running the nursing unit rather than overseeing the home…”*

In light of the above, the panel recognised that unit managers did not meet to discuss issues which affect the running of the Home, and there was not any regular supervision from the manager, and further, that one person had received supervision from a member of staff junior to them. You told the panel that there was a unit manager who did not want to be managed by you and this was a position you appeared to accept. Therefore, this evidenced that, collectively, that you did not have sufficient management and oversight of the whole Home’s leadership team. The panel found the evidence of Ms 1 to be clear and consistent with her report.

The panel therefore concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that adequate systems were in place to monitor the Home's management.

The panel therefore finds this charge proved.

Charge 18a, b and c)

18) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure the Home had an adequate handover sheet to record the following information:

a) How often a patient should be repositioned
b) Specific medical care for residents
c) DNAR statuses"

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence from Ms 3 and the witness statements of Mr 5 and Ms 1. It also had particular regard to paragraph 17 of Ms 1's witness statement, dated 25 February 2019, which corroborates the findings as it sets out:

"In terms of the communication issues identified in the inspection report, this related to things like the use of a handover sheet that wasn't fit for purpose; the copy wasn't clear, bits had come off over time and this meant the system of recording was hit and miss, for example you were unable to tell if it was the day or the night nurse who had recorded something on the sheet…

…

As we were only inspecting the nursing unit, I can't say what handover documentation was like in the other units at Stansty although I noted that while it was mainly agency nurses in the nursing unit, there seemed to be few if any agency nurses in the other units and this was not an issue raised with the Care Inspectorate from other units. The use of agency nurses in the nursing unit was higher than we would have expected for a home of Stansty's size and I recall there were only two nurses on nights and the Unit Manager as the permanent staff for the unit. It appeared and subsequently confirmed by the area managers that the service was having recruitment issues as that organisation was having contractual difficulties with the agency they normally used. I recall this was then resolved and by time of the October inspection, and some of the same regular agency nurses were used. One of the agency nurses we spoke to seemed to know quite a bit about the residents, but reported dissatisfaction with the handover process. High use of agency staff often means a lack of continuity of care, as it is difficult for the carers to get used to different people coming in and the different ways individual nurses work. While it is not unusual for a care home to use agency nursing staff, there were certainly a lot being used at Stansty."

The panel found that the witness evidence of Ms 3 and the witness statement of Mr 5, was consistent with the witness statement of Ms 1. The panel therefore concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure the Home had an adequate handover sheet to record how often a patient should be repositioned, specific medical care for residents nor DNAR status.

The panel therefore finds this charge proved in its entirety.

Charge 19a, b, c, d and e)

19) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that agency staff were given full information on:

a) Specific patients care needs
b) Policy and procedure
c) Where equipment was located
d) Tour of the home
e) Role and/or responsibilities”

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Ms 1. In particular, paragraph 19 of her witness statement dated 25 February 2019, which states:

“As we were only inspecting the nursing unit, I can’t say what handover documentation was like in the other units at Stansty although I noted that while it was mainly agency nurses in the nursing unit, there seemed to be few if any agency nurses in the other units and this was not an issue raised with the Care Inspectorate from other units. The use of agency nurses in the nursing unit was higher than we would have expected for a home of Stansty’s size and I recall there were only two nurses on nights and the Unit Manager as the permanent staff for the unit. It appeared and subsequently confirmed by the area managers that the service was having recruitment issues as that organisation was having contractual difficulties with the agency they normally used. I recall this was then resolved and by time of the October inspection, and some of the same regular agency nurses were used. One of the agency nurses we spoke to seemed to know quite a bit about the residents, but reported dissatisfaction with the handover process. High use of agency staff often means a lack of continuity of care, as it is difficult for the carers to get used to different people coming in and the different ways individual

nurses work. While it is not unusual for a care home to use agency nursing staff, there were certainly a lot being used at Stansty." [sic]

The panel also had regard to the witness statement of Mr 5, dated 17 August 2018, and the oral evidence of Ms 3. The panel found that Ms 1's statement as outlined above supports the accounts of Ms 3 and Mr 5, that there were multiple issues with the handover sheet and that information was not provided correctly, nor did it assist agency staff in understanding the need of people that they were required to provide care and support to.

The panel therefore concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that Agency staff had adequate handover of specific patients care needs, were aware of the policy and procedures, knew where equipment was located, received a tour of the home and were made aware of their role and/or responsibilities.

The panel therefore finds this charge proved in its entirety.

Charge 20)

20) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to escalate safeguarding concerns to the Inspectorate and/or the local safeguarding authority"

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Ms 1 and Mr 4.

The panel had particular regard to paragraph 21 of Ms 1's witness statement, which states:

> *"We also encountered concerns where safeguarding issues had been escalated to the Inspectorate via external professionals, where there was no escalation in kind by the home to the Inspectorate or local authority Safeguarding. The registrant, as Home Manager, was ultimately responsible for escalating concerns. We were told there was a system in place for monitoring and reporting notifiable incidents, but this did not seem to be working. We had received a couple of Safeguarding referrals from the home, but not the number that had actually been picked up by the Health Board staff or social workers going in and out of the home. The home was reporting some, but not all of the relevant concerns and in some instances they reported to the local authority, but not to CIW. We were unable to establish if this was due to the home not reporting incidents, or not recognising safeguarding concerns."*

The panel was of the view that Ms 1's above statement is corroborated by the oral evidence of Mr 4, where he told the panel that once he started looking into some of the concerns raised, he realised that it was not necessarily the safeguarding that needed to be addressed but that you had not met your responsibilities by escalating those concerns.

The panel therefore concluded that, on the balance of probabilities, it was more likely than not that you, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to escalate safeguarding concerns to the Inspectorate and/or the local safeguarding authority.

The panel therefore finds this charge proved.

Charge 21)

21) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that regular management meetings were held with the Unit managers at least every 3 or 4 months”

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statements of Ms 1, where she told the panel that she spoke to staff who said there were no meetings and Mr 4’s, which to some extent contradicted Ms 1’s statement, as he confirmed that you held Unit manager meetings which he had attended.

The panel concluded that there was insufficient documented evidence placed before it to substantiate how frequently you were required to hold meetings and that you had not complied with these requirements. Therefore, there was insufficient evidence before the panel to demonstrate that you, as the Home Manager between May 2017 and October 2017, failed to ensure that regular management meetings were held with the Unit managers at least every 3 or 4 months.

The panel therefore finds this charge not proved.

Charge 22)

22) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that staff received adequate training”

This charge is found NOT proved.

In reaching its decision, the panel considered whether there was any evidence placed before it to indicate that staff did not receive adequate training.

The panel concluded that there was no documented evidence placed before it concerning the training of staff or their training needs. Given this lack of evidence, the panel was not satisfied, on a balance of probabilities, that you failed to ensure that staff received adequate training between May 2017 to October 2017.

The panel therefore finds this charge not proved.

Charge 23)

23) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that unit managers received supervision"

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence of Ms 1, as well as the findings in her report. Ms 1 told the panel that some feedback from some managers at the Home was that they did not receive supervision. Further, you have also told the panel that you did not necessarily provide supervision.

The panel also had regard to the oral evidence of Mr 4, which to an extent contradicts this as he was adamant that supervision was taking place at the Home because of the amount of complaints he was receiving from staff at the time.

However, the panel noted that there were a number of system failures, which should have been identified if adequate supervision was in place. You acknowledged that an appropriate level of supervision was not in place for some staff. Therefore, the panel concluded that it was more likely than not that you, as the Home Manager between May 2017 and October 2017, failed to ensure that unit managers received supervision.

The panel therefore finds this charge proved.

Charge 24a, b, c and d)

24) “That you, in relation to resident 1 between 7th August 2017-19th August 2017, failed to ensure that:

a) she received gluten free meals
b) received her medication on time
c) received hot drinks
d) was cleaned in a timely manner”

This charge is found NOT proved.

In reaching its decision, the panel considered whether there was any evidence placed before it in relation to resident 1 between 7 August 2017-19 August 2017. The panel had regard to the witness statement of Ms 2 and the correspondence with a complaint from resident 1’s family member. The legal assessor also referred the panel to the case of *El Karout* [2019] EWHC 28 (Admin)

The panel concluded that, in relation to resident 1 between 7 August 2017-19 August 2017, there was insufficient evidence placed before it to present a clearer explanation of the situation or witness evidence to prove that you were directly involved in any failure to ensure resident 1 received gluten free meals, received their medication on time, received hot drinks and was cleaned in a timely manner.

The panel therefore finds this charge not proved in its entirety.

Charge 25a, b and c)

25) “That you, in relation to resident 2, failed to ensure that:

a) his bed was suitable and/or in good condition
b) his wound dressings were changed regularly
c) a care plan for repositioning was put in place”

This charge is found NOT proved.

In reaching its decision, the panel considered whether there was any evidence placed before it in relation to resident 2. The panel had regard to the electronic mail correspondence between Ms 2 and resident 2’s relatives regarding a complaint.

The panel concluded that, in relation to resident 2, there was insufficient evidence placed before it to present a clearer explanation of the situation. There was no evidence to prove that you were directly involved in any failure to ensure resident 2’s bed was suitable and/or in good condition, that their wound dressings were changed regularly or that there was a care plan for repositioning put in place.

The panel therefore finds this charge not proved in its entirety.

Charge 26)

26) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure staff answered call bells in a timely manner”

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence of Ms 3 and Mr 4, the complaints from the residents’ relatives and the witness statement of Mr 5.

The panel noted paragraph 6.7 which states:

“general distress of residence at bells were constantly ringing from residents rooms more than any other place I've worked in previously. Residents weren't satisfied with the care they were receiving as there were not enough staff we could not attend to every request or needs.”

Further Section 6 of the Inspection Report dated 28 August 2018 states:

“…We spoke with a member of staff who told us “its stressful rushing around in the morning and service users sometimes get upset if having to wait and night staff sometimes help people to get up”. They also commented, “Call bells go all the time depends on the time of day - get to them as quick as we can could be a few minutes. When two staff are with a service user other people can wait 20 – 30 minutes before staff are able to respond”. This was supported by other staff responses received by questionnaire feedback.” [sic]

In light of this information, the panel was satisfied on the balance of probabilities that there was sufficient evidence to find this charge proved. You failed to put procedures in place to ensure staff answered call bells in a timely manner.

The panel therefore finds this charge proved.

Charge 27)

27) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents were bathed regularly”

This charge is found NOT proved.

In reaching this decision, the panel concluded that there was insufficient evidence placed before it to present a clearer explanation of the situation nor consistent witness evidence

to prove that you were directly involved in the failure to ensure that something was put in place to ensure that residents were bathed regularly. To the contrary it is the evidence of Mr 5 that:

> *"I never found anyone wet or soiled and there were no indications of anyone not being washed."*

The panel therefore finds this charge not proved.

Charge 28)

28) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that colleague 1 was informed that a patient who suffered from Huntingdon's disease required feeding by a nurse"

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statement of Mr 5, dated 17 August 2018, as well as the oral evidence of Ms 1, Ms 3 and Mr 4 in relation to this incident.

The panel considered whether informing colleague 1 that a patient who suffered from Huntingdon's disease required feeding by a nurse forms part of your responsibilities as the Home Manager. The panel concluded that this was not your duty to fulfil at the time as another colleague was in place as unit manager at that time. The responsibility was with them to ensure staff working in the unit were aware of the specific needs of patients.

The panel concluded that there was insufficient evidence that you failed to ensure that colleague 1 was informed that a patient who suffered from Huntingdon's disease required feeding by a nurse.

The panel therefore finds this charge not proved.

Charge 29)

29)"That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents had beds suitable for their needs"

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness evidence from Ms 1 and Ms 3. Their evidence set out that the patients were on the appropriate beds, and although these may not have been used properly, they did have suitable beds for their needs.

The panel concluded that the evidence of Ms 1 and Ms 3 are clear, consistent and credible and that, on the balance of probabilities, it is more likely than not that the residents had beds suitable for their needs.

The panel therefore finds this charge not proved.

Charge 30)

30)"That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents wounds were cleaned on a regular basis"

This charge is found NOT proved.

In reaching this decision, although the panel took into account the witness evidence of Ms 3, it noted that this incident was not documented in the resident's notes and it was Ms 3's

opinion that the wound had not been treated appropriately. The panel noted Ms 3's evidence that the unit manager was on the previous shift and there was no evidence that this was brought to your attention. Further, the panel was not satisfied, on the balance of probabilities, that you were directly responsible at that time as the Home manager.

The panel concluded that there was insufficient evidence placed before it to substantiate that you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that residents wounds were cleaned on a regular basis as this was not within your direct responsibility at the time.

The panel therefore finds this charge not proved.

Charge 31)

31) "That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that an unnamed resident was given liquidated food"

This charge is found NOT proved.

In reaching this decision, the panel took into account the witness statements of Ms 3 and Mr 5 as the agency nurses at the time. The panel also had regard to the evidence of Mr 4, who offered contrary evidence as he indicated there was a white board with this information. The panel noted that Ms 3 did acknowledge in her evidence that carers knew about this information, but that a system was not in place to ensure that Agency staff were fully aware.

The panel concluded that there was insufficient evidence placed before it to substantiate that you, a registered nurse, as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that an unnamed resident was given liquidated food.

The panel therefore finds this charge not proved.

Charge 32)

32) “That you, a registered nurse acting as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that staff were given breaks”

This charge is found proved.

In reaching this decision, the panel took into account the witness evidence from Ms 3 and had regard to the witness statement of Mr 5, which outlined that they were incredibly busy and worked long hours on that day. The panel found that both witnesses were consistent and credible in their evidence in relation to this incident and noted that they were working together on that day. Further, it noted that the staff in the Home were experiencing workload difficulties, which created pressure and impacted their breaks. The panel recognised that ensuring staff were given adequate breaks is the overall responsibility of the Home Manager.

The panel concluded that, on the balance of probabilities, it was more likely than not that you, a registered nurse and as Home Manager of Stansty House Nursing Home between May 2017 to October 2017, failed to ensure that staff were given breaks.

The panel therefore finds this charge proved.

The hearing was resumed on 23 May 2023

Decision and reasons on Notice and proceeding in the absence

This hearing resumed on 23 May 2023. Ms Thornton referred the panel to relevant documentation which proved that Mrs Platt had been informed via email on 18 May 2023 that the initial hearing for this case was adjourned, and was due to resume on 23 May 2023, as well as on 17 and 18 July 2023.

Ms Thornton submitted that the NMC had provided notice as soon as reasonably practicable after the listing was confirmed and complied with the requirements of Rule 32. Ms Thornton submitted that the panel could proceed with resuming the hearing in the absence of Mrs Platt.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mrs Platt had been served with proper notice of this resuming hearing, in accordance with the requirements of Rule 32. The panel decided that it is fair to proceed in the absence of Mrs Platt. The panel will draw no adverse inference from Mrs Platt's absence in its findings.

Interim order

The panel is to make and conclude its decision on misconduct and impairment, but due to lack of time, it must adjourn part way through the case. The panel has therefore 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 Platt's own interests until the 18 July 2023 when the substantive hearing is expected to conclude.

The panel heard and accepted the advice of the legal assessor. The panel was referred to Article 34 (1a), and the NMC guidance on 'Interim orders, their purpose, and when we impose them' (INT-1), which relevant section states:

"When can interim orders be considered?

Our legislation sets out when interim orders can be imposed. Practice committees must consider that an interim order is:

- *necessary to protect the public,*
- *otherwise in the public interest, or*
- *in the interests of the nurse, midwife or nursing associate*

Our practice committees (which will either be the Fitness to Practise Committee or the Investigating Committee, depending on the circumstances) are able to impose interim orders if:

- *an allegation against a nurse, midwife or nursing associate has been referred to the Investigating Committee or the Fitness to Practise Committee but the Committee has not yet reached a final decision. This might be where a final hearing before either Committee adjourns part way through the case, and the panel hearing the case thinks that an interim order is necessary given what they have heard"*

Submissions on interim order

The panel took account of the submissions made by Ms Thornton. She invited the panel to impose an interim order until the next resuming date for this hearing, on the basis that it is necessary for the protection of the public and is otherwise in the public interest.

Ms Thornton submitted that a risk of repetition remains as Mrs Platt has not provided any information to suggest that she has addressed the concerns identified. Further, she submitted that given the panel has found facts proved on a number of charges which are serious in nature and pertain to vulnerable residents in the care home, there is a significant risk of harm should an interim order not be made to restrict Mrs Platt's practice at this stage while the hearing is adjourned.

Ms Thornton invited the panel to consider an interim conditions of practice order should this be suitable and workable until the substantive hearing.

Alternatively, Ms Thornton submitted that should the panel find that the facts proven are sufficiently serious and meet the seriousness threshold to the level of a suspension order, it is the NMC position that an interim suspension order is the appropriate measure to protect the public and is otherwise in the wider public interest.

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 earlier findings.

The panel concluded that an interim order is necessary given what they have heard prior to having to adjourn part way through the case and the risks it has identified in its earlier findings. The panel concluded that to do otherwise would also be incompatible with its earlier findings.

The panel next considered whether to impose an interim conditions of practice order.

The panel had regard to the information before it. It was mindful of its earlier findings that the concerns relate to leadership, management and oversight of the care home, its practices and in ensuring that staff are doing what they should be in order to provide the required level of care for residents. The panel concluded that it did not find concerns relating to Mrs Platt's individual nursing practice.

The panel also noted that Mrs Platt had previously expressed that she is not looking to return to a nursing role, therefore, it concluded that the risk is limited and to impose an interim suspension order would be disproportionate at this stage.

In the light of this, the panel decided that there were workable conditions that could be formulated that would address the risks identified, during the interim period. As such it has determined that the following conditions are proportionate and appropriate:

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 carry out any work, in a clinical setting, which requires you to be in a managerial role.

2. You must not carry out any work, in a clinical setting, which requires you to be in a supervisory role.

3. You must not be the sole nurse on any shift.

4. You must keep the NMC informed about anywhere you are working by:
    a) Telling your NMC case officer within seven days of accepting or leaving any employment.
    b) Giving your NMC case officer your employer's contact details.

5. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your NMC case officer within seven days of accepting any course of study.
    b) Giving your NMC case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any agency you apply to or are registered with for work.
    c) Any employers you apply to for work (at the time of application).
    d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
    e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

7. You must tell your NMC case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

8. You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions'

The panel decided to make this interim order until 18 July 2023, in order to cover the interim period of the adjournment and appropriately protect the public until the hearing resumes on the above date.

This hearing was resumed on 17 July 2023.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Platt was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 18 May 2023.

Ms Thornton referred the panel to documentation and submitted that the NMC has sent communications to the registrant regarding this case, including the notice of hearing, the outcome of the previous decisions and the transcripts of the hearing. She submitted the NMC 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 resuming dates for Mrs Platt's case, her case coordinator's contact information and a link to access the Notice of Resuming Hearing, including instructions on how to join and, amongst other things, information about her 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 Platt had been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in Mrs Platt's absence

The panel next considered whether it should proceed in Mrs Platt's absence. It had regard to Rule 21 and heard the submissions of Ms Thornton who invited the panel to continue in her absence.

The panel had sight of the email correspondence received from Mrs Platt on 17 July 2023. Ms Thornton submitted that there is a strong public interest for the case to proceed in the absence of Mrs Platt. She further submitted that Mrs Platt has a history of engaging and then disengaging from proceedings and has also provided the panel with a written response to the regulatory concerns on 29 May 2018. Ms Thornton submitted that no application for an adjournment of this resuming hearing was sought by Mrs Platt and there is no reason to suppose that adjourning would secure her attendance at a later date.

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.

The panel decided to proceed in Ms Platt's absence. In reaching this decision, the panel has considered the submissions of Ms Thornton, Mrs Platt's e-mail dated 17 July 2023, and the advice of the legal assessor. It 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 Platt informed the NMC that she had received the Notice of Hearing, by way of her e-mail correspondence. The panel noted that she stated she would like to tell her story, but was also mindful that she chose not to participate having been sent the hearing link. Mrs Platt therefore voluntarily absented herself;
- Mrs Platt did not make an application to adjourn this hearing;

- There is no reason to suppose that adjourning would secure Mrs Platt's attendance at some future date; and
- The panel noted that, in her e-mail, Mrs Platt makes reference to the fact this case had been going on for six years. There is a strong public interest in the expeditious continuing and disposal of the case.

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

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 Platt'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 Platt's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

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

Ms Thornton identified the specific, relevant sections of the Code where Mrs Platt's actions amounted to misconduct:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based, including information relating to using any health and care products or services

8 Work cooperatively

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

20 Uphold the reputation of your profession at all times*'*

Ms Thornton identified the specific, relevant standards where Mrs Platt's actions amounted to misconduct. She submitted that Mrs Platt's actions fell below the standards expected of a registered nurse and therefore, the facts found proved amounted to misconduct.

Submissions on impairment

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

Ms Thornton submitted that there is a risk of repetition and that the misconduct put patients in the care home at unwarranted risk of harm, brought the nursing profession into disrepute and breached fundamental tenets of the nursing profession. Therefore, she submitted that Mrs Platt's current fitness to practice is impaired.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

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

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver 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:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

8.6 share information to identify and reduce risk

9 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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

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

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

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

To achieve this, you must:

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

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

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

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

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

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It had regard to the case of *Roylance*, which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Charge 1a

The panel had regard to the context that the Home was in the process of transferring the previous resident files into a new system, but noted the pre-admission assessments were

one of the elements that had not been updated. The panel also noted that the residents were not new patients and had been admitted at the Home for a long period prior to the concerns being raised, so the staff would have been previously aware of their information.

The panel concluded that although these should have been completed, in practice it was not essential considering there were other issues at the Home that required more attention from Mrs Platt. The panel also noted that this charge, individually, did not put the residents at risk of harm as the staff would have already been familiar with their information, having been long term residents. The panel acknowledged that there was a failure in record keeping. However, it determined that this charge was not sufficiently serious to amount to misconduct.

Charge 1c

The panel considered that the failure to ensure that residents files contained updated body maps was very serious due to the risk of harm it posed to residents. Without updated body maps, the review and/or identification of ongoing or new injuries or pressure ulcers requiring intervention could not be carried out by staff if the body maps were not properly updated. The panel determined that this charge amounted to serious misconduct.

Charge 1d

The panel had regard to the context referred to in charge 1a, where the Home was in the process of transferring the previous resident files into a new system. It considered that the failure to ensure that resident files contained an inventory of client belongings was not so serious to amount to misconduct. The panel noted that although this may have been frustrating for the residents and their families, the failure to complete paperwork did not necessarily cause harm to the residents, particularly in terms of their well-being or care at the Home. Further, the panel noted that there were no allegations that any items were missing. Therefore, the panel determined that this charge did not amount to serious misconduct.

Charge 2

The panel considered that the failure to ensure that residents had sufficient food and fluid intake was very serious as it could have significant impact in terms of the residents' physical well-being, where they may need referrals to a specialist or external support. Failure to document accurate food and fluid intake could result in the loss of weight, dehydration or lack of timely intervention for specialist referral and action. The panel had regard to the evidence before it, including the recommendations from the external professional dietitian. It noted that food and fluid intake should have been monitored. The panel determined that this charge amounts to serious misconduct.

Charge 5

The panel had regard to the evidence before it, including the information from the external professional dietitian who recommended the supplements in order to promote the resident's better health. Despite this, Mrs Platt failed to ensure that the resident received his nutritional supplement three times a day as recommended, which put the resident's health and well-being at risk. The panel determined that this charge amounts to serious misconduct.

Charge 7

The panel determined that Mrs Platt's failure to ensure that residents identified as at risk of malnutrition were weighed monthly was very serious as the basic care needs and welfare of residents were not met. This put residents at risk of harm as their health conditions were not being monitored properly. Any decline in health could not be easily identified and the resident provided with the required intervention. This charge therefore amounts to serious misconduct.

Charge 8

The panel considered the failure to ensure that nutritional care plans for residents were reviewed between June 2017 to October 2017 was serious. This is because in not updating these files or keeping them relevant and accurate, the staff were unable to assess the residents' health conditions properly, which could potentially put them at risk of significant harm. This charge therefore amounts to serious misconduct.

Charge 9

The panel determined that Mrs Platt's failure to ensure that residents' care plans were properly audited was serious because it resulted in a failure to highlight issues that could have been resolved earlier if the care plans had been updated. This affected basic elements of care for residents. The panel also noted that these were multiple failures over a period of time and not an isolated incident. This charge therefore amounts to serious misconduct.

Charges 10, 11 and 12

The panel had regard to the information placed before it and was of the view that charges 10, 11 and 12 were interlinked. There were significant failures of oversight, specifically: failure to ensure that assessments for residents at risk of pressure ulcers were updated monthly, failure to ensure that air mattresses for residents were set up correctly and that residents were repositioned regularly in order to avoid tissue damage and failure to ensure that staff were adequately trained in how to use the equipment. These failures demonstrate that there were not appropriate procedures, processes and checks put in place.

The panel heard from the witnesses that assessment documentation was not being updated regularly which indicated that either the record keeping was poor or that some of the residents were not moved for prolonged periods which put them at risk of harm. The panel determined that these charges collectively amounted to serious misconduct as it

was Mrs Platt's responsibility to ensure that the assessments were in place, that staff knew how to use the equipment correctly and that residents were being repositioned.

Charge 13

The panel determined that Mrs Platt's failure to ensure that residents' care plans were reviewed on a monthly basis was serious as this was an important tool that care staff are to use in planning the care for residents. The panel identified that Mrs Platt's role was to ensure that monthly reviews of care plans took place through appropriate supervision of staff. The panel concluded that this failure could lead to inadequate care for residents, therefore putting them at risk of harm. The panel determined that this charge amounted to serious misconduct.

Charges 14 and 20

The panel was of the view that the failure to make referrals to professionals for residents when needed and the failure to escalate safeguarding concerns to the Inspectorate and/or the local safeguarding authority were linked due to their similar nature. The panel determined that both charges were serious as residents had been put at risk as Mrs Platt should have ensured that there were systems and processes in place for the referrals and escalations to take place. Further, the panel recognised that safeguarding is a key responsibility of the Home, so Mrs Platt's role required her to ensure that there was sufficient training on how to escalate concerns or make referrals to professionals. The panel determined that these charges amounted to serious misconduct.

Charges 16a, 16b, 18a, 18b and 18c

The panel determined that Mrs Platt's failure to ensure that adequate instructions were provided for staff on how to administer medication for residents and failure to ensure the Home had an adequate handover sheet to record the relevant information were very serious, particularly as the panel heard evidence that a significant amount of agency staff

were employed. It was extremely important that the staff received appropriate training and instructions to ensure that residents' records were kept up to date, otherwise, the residents could be put at risk of harm as there was a potential of the wrong medication being administered.

Further, the panel noted that some of the residents were particularly vulnerable. In emergency situations, a high level of care is needed for residents and therefore, it is crucial that records are updated should such circumstances arise. The panel determined that these charges amounted to serious misconduct.

Charge 17

The panel noted that in her evidence, Ms 1, stated that:

> *"Every home runs differently; not all homes have unit managers. Our expectation is that whatever the system Stansty had in place, the manager of the home would have some oversight of what was happening and it would be up to them as to how to delegate this, but they should be able to demonstrate how they check that things are being done. We couldn't see any systems like that in place at the time of the October inspection. It appeared due to the absence of the Unit Manager, the registrant's time was focussed on running the nursing unit rather than overseeing the home. I would have expected a home manager, if they didn't have something in place within four months, then they should have a plan for what they would put in place but with the Unit Manager not being in to manage the nursing unit, most of the registrant's time seemed to be spent on running the nursing unit rather than overseeing the home."*

In considering this evidence, the panel is satisfied that the failings identified were serious and amount to misconduct.

Charge 19 in its entirety

The panel determined that the failure to ensure that agency staff were given full information was serious. The panel referred to the evidence it heard that the Home found it difficult to recruit permanent staff and relied on the agency staff. Therefore, it was of vital importance to ensure that agency staff were provided with an induction which included a tour of the Home, complete information on residents' care needs, policies and procedures and where equipment was located and their duties and responsibilities. Not having such systems in place, particularly when the Home relied on frequently changing agency staff, put residents at risk of harm. The panel determined that these charges amounted to serious misconduct.

Charge 23

The panel had regard to the information before it and noted that it heard evidence in relation to concerns with one of the managers at the Home. The panel acknowledged that this could have been avoided or mitigated if supervision took place to pre-empt or intervene with any practical concerns. The panel accepted that there may have been conflict between Mrs Platt and a particular manager. However, this did not exempt Mrs Platt from her responsibility to provide support to individual staff and ensure that unit managers receive adequate supervision. The panel determined that this charge was serious and amounted to misconduct.

Charge 26

The panel determined that the failure to ensure staff answered call bells in a timely manner was within your responsibility. Bells were used by residents to attract attention and not answering them in a timely manner posed a risk of harm to residents. The panel concluded that it was Mrs Platt's responsibility to monitor and ensure that staff were answering call bells in a timely manner. The panel determined that this charge was serious and amounted to misconduct.

Charge 32

The panel heard witness evidence corroborating that staff were overworked and not provided with breaks in a busy environment. The panel acknowledged that it was Mrs Platt's responsibility to ensure that staff were given breaks as it is their legal right and which in turn is likely to be beneficial to residents. Exhausted staff are more likely to put residents in their care at risk through the potential to make mistakes. Therefore, it is fundamental that they are provided with rest and breaks otherwise it could have a detrimental impact on the care that residents receive. The panel determined that this charge was serious and amounted to misconduct.

With the exception of charges 1a and 1d, the panel found that Mrs Platt'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 considered whether as a result of the misconduct, Mrs Platt's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 determined that the limbs a, b and c of *Grant*, as outlined above, are engaged. The panel finds there is a risk of repetition and residents were put at significant risk of harm as a result of Mrs Platt's misconduct. Mrs Platt's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Given ongoing issues with staffing it appeared that Mrs Platt resorted to helping out clinically on a day-to-day basis on one particular unit. The panel have noted that whilst

there were no concerns about her own clinical competence, she failed to provide oversight and intervention in her role as registered nurse who was responsible for managing the Home. The panel were made aware there had been some ongoing concerns at the Home, which were being monitored by the regulators prior to Mrs Platt starting in her position. However, she failed to escalate or address these which perpetuated the issues.

Regarding insight, the panel considered that Mrs Platt recognised that there were failings and issues at the Home but noted that she did not fully accept personal accountability for these. The panel found her insight to be limited as there is insufficient evidence to demonstrate that Mrs Platt had an understanding of how her actions put the residents at a risk of harm or an understanding of how this impacted the reputation of the nursing profession.

The panel was satisfied that the misconduct in this case is capable of being addressed. The panel carefully considered the evidence before it in determining whether or not Mrs Platt has taken steps to strengthen her practice. The panel had no evidence to suggest that Mrs Platt had strengthened practice around leadership and management through relevant training or reflection. Therefore, it could not be satisfied that appropriate remediation had taken place.

The panel is of the view that there is a risk of repetition as there were a wide range of multiple failures over a period of time which have yet to be addressed. The panel considered that, consequently, there remains a significant risk of harm to patients and the public. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel considered there to be a public interest in the circumstances of this case. The panel found that the charges found proved are very serious. It was of the view that a fully informed member of the public would be concerned by its findings on facts and misconduct. The panel concluded that public confidence in the nursing profession would be undermined if a finding of current impairment was not made in this case. Therefore, the panel determined that a finding of current impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mrs Platt'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 18 months. The effect of this order is that Mrs Platt'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

Having found current impairment on Mrs Platt's practice, Ms Thornton submitted that an order is required on the grounds of public protection and is otherwise in the public interest. Ms Thornton referred the panel to the SG and outlined that the guidance suggests that it should consider the aggravating and mitigating features of the case.

The aggravating features proposed by Ms Thornton were:

- A pattern of misconduct over a period of time and an overarching theme of neglect towards vulnerable patients due to their age and dependency to be cared for whilst within the Home.
- Conduct which put patients at risk of suffering harm, in terms of their health but also their safety and wellbeing.
- Insufficient information from Mrs Platt to demonstrate an insight into failings or that she had remediated her practise. No apology, evidence of remorse or admissions put forward by Mrs Platt.

The mitigating features proposed by Ms Thornton were:

- Mrs Platt's written response to the regulatory concerns on 29 May 2018, where she expands on her explanation for the failings, including the context of the culture and practice of the Home.
- Following the October 2017 inspection, Mrs Platt took steps to make improvements to the overall care in the nursing unit within three months.

Ms Thornton submitted that the panel did not have sufficient evidence of insight or remediation from Mrs Platt that could amount to further mitigating features.

Ms Thornton submitted that a real risk of harm remained as the concerns raised were wide-ranging and serious in nature. She submitted that a risk of repetition remained as Mrs Platt has not yet had the chance to demonstrate that she has strengthened her practise since she has not worked in the nursing field for a prolonged period, and having found current impairment on Mrs Platt's practice, an order is required on the grounds of public protection and is otherwise in the public interest.

Ms Thornton submitted that workable conditions of practice could be formulated and suggested that these may include not occupying a managerial role in a clinical setting for a period of time. Ms Thornton invited the panel to consider an interim conditions of practise

order but outlined that it is the panel's discretion if it deems that a more restrictive sanction is more appropriate.

Decision and reasons on sanction

Having found Mrs Platt'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 considered Mrs Platt's written submissions dated 29 May 2018. It also had sight of her recent e-mail dated 17 July 2023 and noted that she expands on her personal circumstances and states:

> *"…I left nursing in 2018 and have never returned, not even as a health care assistant. Do I miss nursing, absolutely, but miss working in a hospital setting on the wards and in theatres only. I feel I've done all my training, and additional training for nothing, I can no longer work in a nursing environment at any level."*

The panel noted that there was no information to suggest that there were concerns regarding Mrs Platt's individual clinical practise.

The panel took into account the following aggravating features:

- A pattern of misconduct, including multiple failures over a period of time
- Failure to escalate and put systems and/or processes in place to resolve the outstanding issues in the Home
- Lack of insight into failings and limited information to demonstrate remediation
- Conduct which put patients at risk of suffering harm

The panel also took into account the following mitigating features:

- Existing issues at the Home prior to Mrs Platt taking on her managerial role
- Lack of sufficient support for Mrs Platt as someone new into the role
- In the context of the culture and performance at the Home prior to Mrs Platt starting her employment, the panel considered whether this was a wider responsibility as opposed to only Mrs Platt's duty
- Partial acknowledgement to failures as outlined in Mrs Platt's written response.

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 Platt's practise 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 Platt'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 Platt'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:

- *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;*
- *No evidence of general incompetence;*
- *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 determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. Whilst, the panel recognised that the charges rely on Mrs Platt's competence and ability on a managerial level, the panel noted that it heard little evidence of concerns relating to Mrs Platt's individual clinical practice.

The panel was informed that Mrs Platt left the profession in 2018 and has not worked in the nursing field since. The panel noted that Mrs Platt has difficult ongoing personal circumstances, that she feels let down by senior management at the Home which has left her feeling that she can no longer work in a nursing environment at any level. However, having had sight of Mrs Platt's email dated 17 July 2023, the panel acknowledged that Mrs Platt misses nursing and working in a hospital on the wards and theatres. The panel concluded from this email it appears that Mrs Platt might be willing to comply with conditions of practice, and that she may wish to return to practice. The panel also found that her misconduct although not at the lower end is remediable.

The panel had regard to the fact that these incidents happened a long time ago and that, other than these incidents, Mrs Platt has had an unblemished career of nearly 10 years as a registered nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Platt should be able to return to practise as a nurse.

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 Mrs Platt's case because there are areas of concern that can be managed with conditions of practice.

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 limit your nursing practice so that you do not work as the nurse in charge or have responsibility for a ward, department or care/nursing home.

2. You must meet with your manager or clinical supervisor on a monthly basis to reflect on, discuss and record your clinical practice progress.

3. You must work with your manager or clinical supervisor to create a personal development plan (PDP). Your PDP must address the concerns about clinical governance, patient safety and audit.

You must send your case officer a copy of your PDP before the next review. This report must show your progress towards achieving the aims set out in your PDP.

4. You must produce a written reflection, which is personally focused on the impact of your actions on the residents and what you have learnt and how your practice has changed. You must send your case officer a copy of this reflection before the next review.

5. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

6. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

7. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.
e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity.

8. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

9. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

Before the order expires, a panel will hold a review hearing to see how well Mrs Platt 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 for another order.

Any future panel reviewing this case would be assisted by:

- Mrs Platt's attendance and engagement at a future review hearing
- A clear idea of Mrs Platt's intentions for the future, e.g. to return to nursing or remove herself from the register.

- A copy of Mrs Platt's PDP and meetings with her manager or supervisor.
- Evidence of professional development – documentary evidence of completion of any courses
- Testimonials from a manager or supervisor that detail current work practices
- A written reflection focused on the impact of Mrs Platt's actions on the residents, what she has learnt and how she has changed her practice.

This will be confirmed to Mrs Platt in writing.

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 Platt's own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Thornton. She submitted that an interim conditions of practice order should be imposed, on the same terms as highlighted above, for a period of 18 months to cover the 28-day appeal period.

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 inconsistent 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 to cover the 28-day 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 Platt is sent the decision of this hearing in writing.

That concludes this determination.