Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 11 April 2023 – Friday, 14 April 2023
Monday 18 September 2023 – Tuesday 19 September 2023

Virtual Hearing

Name of Registrant:	**Heather Allison**
NMC PIN	79A0561S
Part(s) of the register:	RN1: Registered Nurse – Adult, level 1 (1 July 1982) RN5: Learning disabilities nurse, level 1 (13 April 1983)
Relevant Location:	Dundee
Type of case:	Misconduct
Panel members:	Dave Lancaster (Chair, Lay member) Hannah Harvey (Registrant member) Simon Banton (Lay member)
Legal Assessor:	Charles Parsley
Hearings Coordinator:	Max Buadi (11 – 14 April 2023) Sophie Cubillo-Barsi (18-19 September 2023)
Facts proved:	Charges 1a) (pertaining to Schedule A 1 – 7 and 9 - 11) Charge 2 (pertaining to Schedule B 1 - 3) Charge 4a (pertaining to Schedule C 1 - 5, 8, 10 - 12) Charge 5a (pertaining to Schedule D 1 – 9) Charge 6 (pertaining to Schedule E 1 – 16) Charge 7 (pertaining to Schedule F 1 – 8)
Facts not proved:	Charges 1a) (pertaining to Schedule A 8, 12 and 13) and Charge 1b)

	Charge 2 (pertaining to Schedule B 4) Charge 3 Charge 4a (pertaining to Schedule C 6,7 and 9) and 4b Charge 5b
Fitness to practise:	Impaired
Sanction:	**Striking off order**
Interim order:	**Interim suspension order – 18 months**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Allison's registered email address by secure email on 16 February 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

The panel also took account of an email response from Mrs Allison, dated 12 October 2022, which stated:

> *"I will not be participating in this.*
> *I have never been able to get egress to work and I don't really want to read about it all…"*

In the light of all of the information available, the panel was satisfied that Mrs Allison has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charges

That you, a registered nurse, whilst the manager of Bridgeview House Care Home ('the Home'):

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

    a) including, but not limited to, as set out in Schedule A;
    b) generally;

2) Failed to complete required training as set out in Schedule B;

3) Failed to maintain appropriate staffing levels at the Home and/or ensure that there was a contingency plan for staff shortages;

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;
   b) generally;

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

   a) as set out in Schedule D;
   b) generally;

6) Behaved in the manner set out in Schedule E;

7) Failed to maintain professional boundaries with Resident A, as set out in Schedule F.

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

SCHEDULE A	
1	Did not upload infection control audits onto 'Radar' on one, or more, occasion
2	Did not complete and/or submit Covid-19 'Record of Outbreak reports on one, or more, occasion
3	Did not ensure that 'Phase 1' of the policies were implemented timeously
4	Did not ensure that medication audits were undertaken as required and/or at all
5	Did not ensure that one, or more, medication errors were recorded
6	Did not ensure that the controlled drugs books were checked regularly
7	Did not ensure that one, or more, care plan audits were progressed/completed timeously and/or at all
8	Did not ensure that one, or more, pressure damage ulcers were recorded on

	‘Radar’ and/or the Home Managers Monthly Audit (‘HMMA’)
9	Did not ensure that one, or more, patient’s BMI/weight recorded on the Home Managers Monthly Audit (‘HMMA’) corresponded with the BMI/weight recorded on the patient file
10	Did not review the Homes ‘dependency’ assessments and/or ensure that they were review timeously
11	Did not ensure that the “resident of the day” review system was implements on one, or more, occasion
12	Did not implement a ‘Radar’ action plan
13	Did not address and/or evidence the actions taken to address the actions arising from an inspection completed by the Care Inspectorate in April 2019

SCHEDULE B	
1	Did not engage with and/or talked through training on 04 February 2020
2	Did not complete your induction booklet
3	Did not complete the required e-learning/online toolkits/training timeously and/or at all
4	Did not complete the Deputy Manager’s induction

SCHEDULE C	
1	Did not ensure that relevant / required equipment was in place when Resident D was admitted to the Home
2	Admitted Residents A and/or B and/or C to the Home without ensuring that staff and/or the Home was able to meet their specialised needs
3	Told a member of staff to “mind their own business” or words to that effect, when suggesting that a syringe driver be used in relation to Resident K
4	Did not ensure that one, or more, members of staff were trained to provide appropriate care for Resident K
5	Did not ensure that one, or more, members of staff were trained in the use of syringe drivers and/or palliative care
6	Admitted Resident E to the Home without enduring that staff and/or the Home was able to meet their specialised need
7	Did not ensure that one, or more, members of staff were trained to provide appropriate care for Resident E
8	Did not ensure that a colleague who raised concerns relating to the case of Resident J was supported
9	Admitted Resident F to the Home without ensuring that staff and/or the Home was able to meet their specialised needs
10	Did not ensure that the Home and/or staff were able provide appropriate care for Resident F

11	Did not ensure that Resident I's pain relief medication was escalated and/or reviewed timeously
12	Did not ensure that the wardrobe in Resident H's room was safe and/or attached to the wall

SCHEDULE D	
1	Did not ensure that the Home was in an appropriate standard of cleanliness as at the date of the inspection on 17 June 2020
2	Did not ensure that one, or more, items of care equipment were clean and/or in repair as at the date of the inspection on 17 June 2020
3	Did not ensure that cleaning duties were increased as at the date of the inspection on 17 June 2020
4	Did not ensure that there was a proper audit process was in place at the Home to ensure proper cleanliness and infection control was in place as at the date of the inspection on 17 June 2020
5	Did not ensure that the infection control checklist was implemented at the Home as at the date of the inspection on 17 June 2020
6	Following an inspection on 17 June 2020, the Homes was given an inspection grade of '1' in relation to Infection Prevention and Control
7	Did not ensure that staff were given correct PPE and/or knew what guidance to follow during the Covid pandemic
8	Did not ensure that one, or more, members off staff had up to date infection control training
9	Did not ensure that the Home followed the proper process for disposal of clinical waste

SCHEDULE E	
1	From in, or around, Summer 2018, said to Colleague 1, "You are not doing your job properly" or words to that effect
2	In, or around, October 2018, said to Colleague 1, "You don't; want to mess with me because you know I can destroy you" or words to that effect
3	In, or around, November 2018, said to Colleague 1, "Do you have something to tell me" or words to that effect when asking about an alternative job
4	At, or around, the end of November 2018, contacted/e-mailed a prospective employer of Colleague 1 and informed them that Colleague would not take up a job with the prospective employer
5	On one, or more, occasions, threw communication at Colleague 1, when being asked to approve an "off duty" request
6	On one or more, occasion, shouted at Colleague 1
7	On one, or more, occasion pointed in Colleague 1's face
8	On an unknown date, screamed and/or shouted at Colleague 2 when discussing Resident E
9	On an unknown date, pointed your finger close to Colleague 2's face when

	discussing Resident E
10	On an unknown date, stated word to the effect of “this is ridiculous, if I was working with HC-One we would have sacked her” when referring to Colleague 4
11	On an unknown date, contacted a prospective employer of Colleague 4 and stated that they were unemployable, or words to that effect
12	On one, or more occasion, said the you wanted Colleague 5 “gone”, or words to that effect
13	On an unknown date, shoved Colleague 6 in the back
14	On an unknown date said to Colleague 3, “Your colleagues don’t like working with you and they don’t think you are good at your job”, or words to that effect
15	On an unknown date said to Colleague 3, “Don’t ignore me [Colleague 3]”, or words to that effect
16	In, or around, the end of 2019, contacted a prospective employer of Colleague 3 and stated that they were unemployable, or words to that effect

SCHEDULE F	
1	Permitted and/or allowed Resident A to call you “mum” and/or “work mum”
2	Gave Resident A, a photograph of yourself
3	On one, or more, occasion, made comments about taking Resident A to you house for the weekend
4	Instructed one, or more, members of staff to take Resident A to a restaurant and/or buy Resident A a toy, when the resident had behaved in a challenging or aggressive manner
5	On one, or more, occasion, said you wanted to take Resident A and/or their sibling(s) home
6	Cuddled and/or stroked Resident A’s hair
7	Gave Resident A, and their sibling, a present when you returned from leave
8	Following Resident A having been moved to alternative accommodation, said to Colleague 1 and /or Colleague 2, that they had “overstepped the mark”, or words to that effect

Background

Mrs Allison commenced her role as the manager of the Bridgeview House Care Home ("the Home") in May 2017. The concerns arose when Mrs Allison, an experienced nurse, was manager of the Home and covered a period from 2018 up until she resigned from her role on 22 June 2020.

The referral was made shortly thereafter on 17 July 2020.

The concerns are related to Miss Allison's alleged poor management of the home, her fractious interactions with other staff and her relationship with residents.

Concerns were raised by a group of employees in April 2019 regarding Mrs Allison's management of the home and the impact this was having on both residents and the staff. Those same staff have provided evidence suggesting that Mrs Allison was 'volatile' and have since made accusations of bullying which have had a real impact on their wellbeing.

The evidence gathered during the investigation suggests that Miss Allison's conduct, and the poor management of the home continued for some time, but concerns escalated following the acquisition of the Home by Sanctuary Care on 10 January 2020. The Home was subject to a Care Inspectorate inspection on 17 June 2020.

Evidence from those involved with both the new ownership of the Home and those from the Care inspectorate noted that the Home was in a poor state, and they commented particularly on Miss Allison's failures to implement relevant policies and her alleged reluctance to engage in resolving these issues.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the NMC's statement of case and an email from Mrs Allison.

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 facts will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Ms 1: Regional Director for Sanctuary Care;

- Ms 2: Quality Assurance Manager for Sanctuary Care;
- Ms 3: Regional Manager for Sanctuary Care;
- Ms 4: At the relevant time, Senior Inspector for Care Homes at Healthcare Improvement Scotland;
- Ms 5: Senior Inspector for Care Homes at Healthcare Improvement Scotland;
- Ms 6: At the relevant time, a Charge Nurse at the Home;
- Colleague 1: At the relevant time, Clinical Lead at the Home;
- Colleague 3: At the relevant time, a Carer at the Home;
- Colleague 2: At the relevant time, Deputy Manager at the Home;
- Ms 7: At the relevant time, House Administrator at the Home.

When considering these charges, the panel noted that throughout her employment at the Home, Mrs Allison's terms and conditions of employment were those of the previous owner, those of Sanctuary Care not having applied to her. The panel did not have sight of any terms of employment but considered the issues raised in the context of her practice as a registered nurse and home manager.

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

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
1	Did not upload infection control audits onto 'Radar' on one, or more, occasion

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 2 and Ms 3.

Ms 2 in her witness statement stated:

> *"On 13 March 2020 I attended the Home for a 'support visit' to help the Registrant get to grips with using Radar…I worked alongside the Registrant and showed her the process of competing and uploading actions…"*

The panel was satisfied that Mrs Allison was shown how to use Radar.

Ms 3 in her witness statement stated:

> *"On 29 April 2020 | conducted a 1:1 meeting with the Registrant over video chat as I was unable to go to the Home after the UK went into lockdown…During this meeting, the Registrant was very negative towards the Sanctuary policies and procedures, and told me that she preferred her own way of doing things because she felt that she did not have time to log things onto Radar. In particular, I could see on the Radar system that the Registrant had not been uploading the infection control audits onto Radar. I asked the Registrant why she was not complying with*

the Sanctuary systems and procedures and asked if she wanted more training. The Registrant told me that she understood the systems perfectly well but just didn't have time to comply…"

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 2 and Ms 3.

The panel took account of the note taken during a support telephone call between Ms 3 and Mrs Allison on 6 May 2020, which stated:

"Discussion around Radar and keeping it updated. [Ms 8] kindly put the COVID reports into Radar and we were able to update some of those with results or close them, we have some actions from the Quality audit which we have moved the dates of as Heather could not manage them in the time frame given."

In light of the above, the panel was satisfied that Mrs Allison did not upload infection control audits onto 'Radar' on one, or more, occasion.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 1 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
2	Did not complete and/or submit Covid-19 ‘Record of Outbreak reports on one, or more, occasion

This charge is found proved.

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

Ms 3 in her witness statement stated:

> *“…[Ms 8] input the Home's Covid-19 reports into Radar. At this time, Sanctuary Care's management was sensitive to the fact that Home Managers were working in a pandemic so we were happy to assist with this, to lessen the burden on the Registrant.”*
>
> *“…I also reminded the Registrant that Covid-19 'Record of Outbreak' reports had to be submitted daily along with an update on deaths and staff sickness. This involved filling out a simple table with the names of residents who had tested positive for Covid-19. The Registrant said that she did not have time to do this, so I suggested to her that she could complete the table and that [Ms 8] could upload the information to Radar for her…”*

The panel took account of the note taken during a support telephone call between Ms 3 and Mrs Allison on 6 May 2020, which stated:

> *“Discussion around Radar and keeping it updated. [Ms 8] kindly put the COVID reports into Radar and we were able to update some of those with results or close them, we have some actions from the Quality audit which we have moved the dates of as Heather could not manage them in the time frame given.”*

The panel also took account of the Covid-19 'Record of Outbreak' report, dated 2 April 2020. It noted that the “DOB” and “Date symptoms started” fields for Resident NY and KI had not been completed.

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 3.

In light of the above, the panel was satisfied that Mrs Allison did not complete and/or submit Covid-19 ‘Record of Outbreak reports on one, or more, occasion.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 2 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
3	Did not ensure that ‘Phase 1’ of the policies were implemented timeously

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *“In order to help the home transition into Sanctuary Care, we decided to slowly implement the policies over three 'phases' and gave out the first twenty policies to*

all services in January 2020 to be rolled out by 24 April 2020. We called this 'phase 1', which covered the most important policies.

On 27 March 2020, I emailed…Business Analyst, with a list of the care homes that had completed the top 20 policy reading...As can be seen from this email, only 26 percent of Bridgeview staff had read the phase 1 policies. I have been asked to evidence where this percentage figure came from. I recall that it was provided by the Regional Manager [Ms 3], but I cannot now find documentation to demonstrate this. As Home Manager, the Registrant should have made sure that staff were reading and signing off on the policies…"

The panel took account of the Thistle Handbook which demonstrated what needed to be done. It also took account of the email sent by Ms 1 to the Business Analyst dated 22 December 2020 which stated:

"Following our call earlier last week [Ms 9] and [Ms 3] have been chasing the services for completion of the top 20 policies.

Below are the % of staff who have read all 20.
…
Bridgeview 26%..."

The panel also took account of an email from Mrs Allison regarding the percentage of staff who had read first 20 policies, dated 15 June 2020. It stated:

"We are sitting at 25% read and all have been reminded again to read and sign."

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that 'Phase 1' of the policies were implemented timeously.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 3 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
4	Did not ensure that medication audits were undertaken as required and/or at all

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

"I looked at the Radar system at the Home and found that the following were incomplete:

1. *Medication audits: The Registrant told me that she did not think that a medication audit had taken place since December 2019, and the system showed that one should have been performed on or by 28 February 2020. There is an audit planner which was communicated to all new managers at the training on the 4 of February 2020. The medication audit is completed monthly to check that medications are being ordered, stored, administered, and recorded correctly. It is the home managers' responsibility to ensure the audits are carried*

out on time. The potential risk of not completing these medication audits was there if there were any anomalies, they may not be brought to light."

The panel took account of the Audit report completed by Ms 1 on the visit of 10 March 2020. It demonstrated that Mrs Allison had completed the medication audit on 30 March 2020 and not by 28 February 2020 as required.

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that medication audits were undertaken as required and/or at all.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices/ensure were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 4 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
5	Did not ensure that one, or more, medication errors were recorded

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *"I looked at the Radar system at the Home and found that the following were incomplete:*
>
> *…*
>
> > *Medication errors: The Registrant told me that she was not aware of any medication errors. However, when I checked some of the Medication Administration Records I identified twelve gaps in recordings. Again, I do not have documentary evidence to exhibit for this observation, because I did not take photographs, copies, or screenshots of any of the documents or software pages that I reviewed…"*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

The panel took account of the Audit report completed by Ms 1 on the visit of 10 March 2020 which stated that there were errors in medication.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that one, or more, medication errors were recorded.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 5 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
6	Did not ensure that the controlled drugs books were checked regularly

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *"I looked at the Radar system at the Home and found that the following were incomplete:*
> *…*
> *Medication errors:…Additionally, I noted that the Registrant had not been checking and signing the controlled drugs book weekly. The implication of this was that the Registrant had no oversight that medication was not being recorded properly, nor was she addressing poor practice with her staff... It is the manager's responsibility to ensure this is completed."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that the controlled drugs books were checked regularly.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 6 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
7	Did not ensure that one, or more, care plan audits were progressed/completed timeously and/or at all

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *"I looked at the Radar system at the Home and found that the following were incomplete:*
> *…*
> *"Care plan audits: I found that there were three overdue care plan audits and just one in progress, but it had not been progressed since 27 February 2020. The Home have a number of care plan audits to carry out each month, and the actions from these audits need to be completed and signed off. This had not been done and I saw that the actions remained outstanding on the Radar system. In discussions with the Registrant, it was clear to me that she was aware of this and had not ensured that the audits had been completed."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

The panel noted that the requirements of the care plan audits, namely that they were to be added to Radar, were eventually met on 20 March 2020. However, they were not progressed and completed timeously.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 7 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
8	Did not ensure that one, or more, pressure damage ulcers were recorded on 'Radar' and/or the Home Managers Monthly Audit ('HMMA')

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *"I found that not all pressure damage ulcers were recorded onto Radar. During the Radar training on 4 of February, [Ms 2], who provides Quality Assurance Manager Support, introduced the managers to the Home Managers Monthly Audit ("HMMA") and showed them how to complete it. The HMMA is where home managers can record all residents who they consider to be 'at risk'. This would include all residents*

with weight loss or pressure damage, and those who had suffered falls or hospital admissions etc. The purpose of this is that the residents who are highest risk can be closely monitored. The information recorded on Radar and on the HMMA should match up, but my RMCV revealed that this was not the case. As is commented at page 9 of my report…, the Registrant informed me that a resident had a grade 4 pressure sore but, on checking, this had not been recorded not on Radar…The Registrant confirmed to me verbally that she was aware this should have been reported on Radar. It had also been as covered in the training delivered on 4 February 2020."

The panel bore in mind that the charge alleges that Ms Allision did not ensure that "one, or more, pressure damage ulcers were recorded on 'Radar' and/or the Home Managers Monthly Audit ('HMMA')". However, it noted that there appeared to be an inference that Ms Allision did record the pressure damage ulcers on HMMA and was only recorded Radar at a later date.

The panel reminded itself that it is for the NMC to prove the charge. However, the panel concluded, on the balance of probabilities, that the evidence adduced by the NMC was insufficient to establish that Mrs Allison did not address and/or evidence the actions taken to address the actions arising from an inspection completed by the Care Inspectorate in April 2019.

The panel therefore found Schedule A 8 of charge 1 not proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
9	Did not ensure that one, or more, patient's BMI/weight recorded on the Home

	Managers Monthly Audit (‘HMMA’) corresponded with the BMI/weight recorded on the patient file

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *“I looked at the Radar system at the Home and found that the following were incomplete:*
> *…*
> *Body Mass Index: I found that the weights recorded in the HMMA differed from the weights recorded on the care files of the residents. It is the home managers' responsibility to ensure all information recorded on the HMMA is accurate and correct. This was also explained during the training delivered on the 4 of February 2020 by [Ms 2]. I know this because I was present at that training.”*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that one, or more, patient’s BMI/weight recorded on the Home Managers Monthly Audit (‘HMMA’) corresponded with the BMI/weight recorded on the patient file.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices/ensure were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 9 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
10	Did not review the Homes 'dependency' assessments and/or ensure that they were review timeously

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *"In the Home Management section, I found the following areas to be incomplete:*
>
> *Dependency levels v rota: | looked at whether the dependency levels of the residents were matched with appropriate staffing levels. There was sufficient care staff in place to meet the needs of the residents' care, however I reviewed the dependency assessments and found that the Registrant had not reviewed them for a few months. It is a requirement of the Care Inspectorate that the service should provide a four-weekly assessment of dependencies and staffing deployment. This is a requirement for all care services not just Bridgeview…"*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

In light of the above, the panel was satisfied that Mrs Allison did not review the Homes 'dependency' assessments and/or ensure that they were review timeously.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 10 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
11	Did not ensure that the “resident of the day” review system was implements on one, or more, occasion

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *“In the Home Management section, I found the following areas to be incomplete:*
>
> *Resident of the day: This is a system where each day the care file for one resident is reviewed. This means that all care plans and risk assessments are evaluated and updated as required. I found that the 'resident of the day' had not been completed for a while and the care plans that I checked had missing evaluations. This meant that the care plans may not reflect the current care needs of the residents. I have been asked whether I can evidence this, but unfortunately, I only have the comment made at "RMCV-3-7" on page11 of Exhibit DH/05. I will state that implementing a*

resident of the day' procedure is not a Sanctuary Policy but is just an example of good practice that I would encourage home managers to make use of.

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

The panel took account of the Audit report completed by Ms 1 on the visit of 10 March 2020. It stated *"The [Resident of the Day] has not been completed for a while and care files I checked had missing evaluations"*

In light of the above, the panel was satisfied that Mrs Allison did not ensure that the "resident of the day" review system was implemented on one, or more, occasion.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to ensure that updated practices/ensure were implemented following the takeover of the Home by Sanctuary Care.

The panel therefore found Schedule A 11 of charge 1 proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
12	Did not implement a 'Radar' action plan

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *"…I discussed with the Registrant what needed to be done following my visit, and I produced an action plan for her on Radar which can be found at pages 1 to 7of the report…However, as it can be seen on the right hand side of pages 1 to 7 of the compliance visit audit sheet…the majority of the action plan was completed by the end of March 2020 and fully complete by June 2020"*

The panel took account of the Audit report completed by Ms 1 on the visit of 10 March 2020. It noted that there is a specific reference to a radar plan in "RMCV-16" which stated that it had not been completed. However, the panel took the view that pages 1-7 referenced by Ms 1 related to the overall radar action plan. The panel noted that most of this had been completed.

In light of the above, the panel was satisfied that Mrs Allison did implement a 'Radar' action plan.

The panel therefore found Schedule A 12 of charge 1 not proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

   a) including, but not limited to, as set out in Schedule A;

SCHEDULE A	
13	Did not address and/or evidence the actions taken to address the actions arising from an inspection completed by the Care Inspectorate in April 2019

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

The panel reminded itself that the stem of the charge stated, “Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care”. However, it bore in mind that Sanctuary Care took over the Home on 10 January 2020.

The panel took account of the Care Inspectorate Report, dated 30 April 2019 and noted that this date was before Sanctuary Care took over the Home.

The panel reminded itself that it is for the NMC to prove the charge. However, the panel concluded, on the balance of probabilities, that the evidence adduced by the NMC was insufficient to establish that Mrs Allison did not address and/or evidence the actions taken to address the actions arising from an inspection completed by the Care Inspectorate in April 2019.

The panel therefore found Schedule A 13 of charge 1 not proved.

Charge 1

1) Failed to implement updated practices/ensure that updated practices were implemented following the takeover of the Home by Sanctuary Care:

    b) generally;

This charge is found not proved.

The panel was of the view that it could not find more examples of Mrs Allison’s failure to implement updated practices following the takeover of the Home by Sanctuary Care beyond those it found proved within Schedule A.

The panel therefore found this sub-charge not proved.

Charge 2

2) Failed to complete required training as set out in Schedule B;

SCHEDULE B	
1	Did not engage with and/or talked through training on 04 February 2020

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *"The next time that I met the Registrant was on a training day on 4 February 2020. The day was arranged to provide the new managers with training on the accidents and incidents reporting system that Sanctuary uses called 'Radar'…I attended the training day so that I could observe and see how this training was received. It was my perception that the Registrant was particularly negative. For example, she stated how she did not have time for the training, and there was no need to have to record all this information. She was also negative about her line manager, [Ms 3], stating "all she does is send me stuff all the time which I won't be doing as I don't have time for all that." The Registrant also sat chatting to two other colleagues while presentations were being delivered."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

In light of the above, the panel was satisfied that Mrs Allison did not engage with and/or talked through training on 04 February 2020.

The panel therefore found Schedule B 1 of charge 2 proved.

Charge 2

2) Failed to complete required training as set out in Schedule B;

SCHEDULE B	
2	Did not complete your induction booklet

This charge is found proved.

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

Ms 1 in her witness statement stated:

> *"With regards to home stability, I found that the following areas were incomplete:*
>
> *1. Manager induction: The Registrant had not completed any part of her induction. The induction was in the form of a booklet...It is my understanding that there was support provided from…her buddy, [Ms 2], and her line manager, [Ms 3] to help go through her induction."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 1.

The panel took account of the Home Manger Induction Toolkit provided by Ms 3 but noted that it was a sample and not Mrs Allison's actual induction booklet.

Nevertheless, in light of the above, the panel was satisfied that Mrs Allison did not complete her induction booklet.

The panel therefore found Schedule B 2 of charge 2 proved.

Charge 2

2) Failed to complete required training as set out in Schedule B;

SCHEDULE B	
3	Did not complete the required e-learning/online toolkits/training timeously and/or at all

This charge is found proved.

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

Ms 3 in her witness statement stated:

> *"In the first week of January 2020, Sanctuary Care arranged a training day for the Registrant and the other Home Managers who were new to Sanctuary Care…Every Home Manager, including the Registrant, was given a Home Manager Induction Toolkit …Section 4 at page 60 of the toolkit sets out the e-learning programme for Home Managers. Each Home Manager was responsible for going online and completing the training set out in the Toolkit within the timescale given.*
>
> *By 30 June 2020, The Registrant had only completed five out of the 15 online training courses made available to her online..."*

The panel took account of the Home Manger Induction Toolkit. It noted that the required e-learning had to be completed in three months. As the induction was in January 2020, this would give Mrs Allison until April 2020 to complete the required e-learning.

The panel also took account of the specified four-week induction programme within the Home Manager Induction Toolkit. It noted that the specified e-learning are highlighted in blue and each are given a timescale for completion ranging from 30 minutes to just over two hours. It noted that these were not completed.

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 3.

In light of the above, the panel was satisfied that Mrs Allison did not complete the required e-learning/online toolkits/training timeously and/or at all.

The panel therefore found Schedule B 3 of charge 2 proved.

Charge 2

2) Failed to complete required training as set out in Schedule B;

SCHEDULE B	
4	Did not complete the Deputy Manager's induction

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Ms 1.

Ms 1 in her witness statement stated:

> *"With regards to home stability, I found that the following areas were incomplete:*
> …
> *Deputy Manager induction: The Registrant informed me that she had not completed the Deputy Manager's induction either. This was a verbal conversation, so I have no documentary evidence to exhibit. The Deputy Manager…had commenced employment in November 2019. However, The Registrant had not completed any form of induction with her."*

However, the panel noted that when the Deputy Manager commenced employment on 19 November 2020, Mrs Allison had not completed her own induction.

The panel reminded itself that it is for the NMC to prove the charge. However, the panel concluded, on the balance of probabilities, that the evidence adduced by the NMC was insufficient to establish that Mrs Allison had a duty to complete the Deputy Manager's induction.

In light of the above, the panel therefore found Schedule B 4 of charge 2 not proved.

Charge 3

3) Failed to maintain appropriate staffing levels at the Home and/or ensure that there was a contingency plan for staff shortages;

This charge is found not proved.

In reaching this decision, the panel took account of the evidence Ms 1 and Ms 5.

Ms 5 in her witness statement stated:

> *"I also looked at whether the staffing numbers were sufficient for the needs of the residents. Staff told us that they were often short of staff and this impacted negatively on resident care. I did not find evidence of a contingency plan for staff shortages. A contingency plan is necessary to ensure there is adequate staff to support and care for residents, particularly where people were likely to have higher than normal support needs if unwell with coronavirus. The provider is ultimately responsible for ensuring contingency planning. The registered manager is then responsible for arranging and implementing that plan. Due to the virus, staff were stretched and struggled to fully meet the needs of the residents."*

The panel took account of the "Sanctuary Care policy roll out spreadsheet" provided by Ms 1. It noted that *"Absence Management – Group Policy and Procedure"* was part of phase 3 dated 1 July 2020 to 30 August 2020. This would have been after Mrs Allison had left the Home.

The panel took account of the “Completed Record of Inspection sheet for the staffing criteria” which raised concerns about the inadequate staffing levels at the Home. However, again it bore in mind that this was during Covid-19. It also took account of an email sent by Mrs Allison to the NMC dated 12 October 2022 which stated:

> *“…This was a horrific time for me. I was watching people die and there was nothing I could do about it. Staff were haemorrhaging out in fear and also shielding. We tried out best with no support from our company and they laid the blame at our door…”*

While the panel accepted that as the Manager of the Home, Mrs Allison had a responsibility to maintain appropriate staffing levels, it bore in mind that this incident occurred during the height of the Coronavirus Pandemic in 2020. People during this time were self-isolating for two weeks and staff and patients were sick.

The panel also took account of WhatsApp messages exchanged between Mrs Allison and staff in April 2020 where it appears that staff were scared to go to work at the Home. The messages also mentioned that the Home did not want to employ agency staff during this period due to the potential of Covid spreading. Due to this pandemic, the panel accepted that there were circumstances beyond her control.

In light of the above, the panel was satisfied that there was no policy in place for adequate staffing levels and no evidence of a contingency plan for potential staff shortages whilst Mrs Allison was the manager at the Home. This was confirmed by Ms 5 who also stated that Sanctuary Care would have been ultimately responsible for contingency planning. Therefore Mrs Allison, given the circumstances and the environment she was operating in, could not possibly be responsible for implementing any such plan when it apparently did not exist.

The panel therefore found this charge not proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;

SCHEDULE C	
1	Did not ensure that relevant / required equipment was in place when Resident D was admitted to the Home

This charge is found proved.

In reaching this decision, the panel took account of the evidence of

Colleague 2 in her witness statement stated:

> *"At that time room 29 was being refurbished and I went to see whether it was suitable for Resident D. There were no curtains, there was no toilet seat on the toilet, and the bedrails had not been put up. Resident D' amputation was at the thigh on one of his legs which meant we would need a certain type of sling in order to lift him safely and transfer him into bed. The Home had a lifting machine and slings but only those that hooked under resident's legs in order to lift them, so this would not have been safe to use for Resident D."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Colleague 2 as she is a Staff Nurse who witnessed the issue.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that relevant / required equipment was in place when Resident D was admitted to the Home.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to

provide and/or ensure that an adequate standard of care was provided to the residents at the Home.

The panel therefore found Schedule C 1 of charge 4 proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;

SCHEDULE C	
2	Admitted Residents A and/or B and/or C to the Home without ensuring that staff and/or the Home was able to meet their specialised needs

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Colleague 1, Colleague 3 and Colleague 2.

Colleague 2 in her witness statement stated:

> *"On one occasion, at about 18.30 or 19.00 in the evening, three individuals arrived at the Home by taxi accompanied by an agency nurse with the expectation that they were going to be admitted. They were all adopted siblings, Resident A was 26 years old, and Resident B and Resident were 32. There was no paperwork accompanying them. Usually essential documents would be sent to the Home before a resident arrived, so we would know what their care needs were and what medication they were on. The nurse escorting them had only met them that day and knew very little about them, only that they had been living in the countryside with their adopted parents and the family had broken down. I brought them inside and got them settled in the lounge with something to eat and drink. They were very frightened and it was evident that Resident A and Resident C had severe learning difficulties as they were struggling to communicate. We later found out that Resident had a genetic*

syndrome that caused her mental age to be around two or three, and Resident was severely autistic. Resident B had full mental capacity but she was physically disabled, I believe she had cerebral palsy.

The Home was registered for adults over the age of 65 so it was my understanding that the admission of the [Residents A, B and C] was a breach of our agreement with the Care Inspectorate and that the Home should have applied for permission to house them and justify how we were able to meet their needs Resident A's behaviour proved to be very challenging. She suffered from seizure type episodes where she had involuntary jerking movements and would foam at the mouth. She was constantly running around the Home, she assaulted members of staff including myself, she trashed her room, and on more than one occasion she stripped naked and threw her sanitary towels at other residents. There are nurses who are qualified to nurse individuals with learning disabilities but none of the nurses at the Home had this kind of background, apart from the Registrant. I am trained as an adult nurse and caring for Resident A was completely out of my skillset.

I believe that the Care Inspectorate were made aware of challenging behaviour in the Home in relation to Resident E , although I cannot recall when this was. When an inspector attended the Home, they then witnessed Resident A behaviour and were concerned. I got the impression that the Care Inspectorate had queried with the Registrant which staff in the Home had training in learning disabilities because I recall the Registrant asking everyone where they had worked previously. One of the carers had worked with Gowrie healthcare, which I believe is a specialist organisation, and the Registrant herself had training. It is my view that the Registrant was trying to fudge the team's qualifications after the fact. She did not know who had mental experience when she accepted Resident A and Resident C into the Home. I believe that the Care Inspectorate were not satisfied and they upheld the complaint"

Colleague 1 in her witness statement stated:

"In or around May 2018, I cannot recall exactly when, three residents were admitted to the Home who all had learning disabilities. I understood that the placement was

supposed to be respite for six weeks after their mother had had a stroke and there was found to be neglect in the home. All three of these new residents were adoptive siblings: Residents A, B, and C One of them, R:A had extremely challenging behaviour. For example R:A would physically assault staff at the Home, I understand that there were incident reports for these assaults at the time. There was one occasion where R:A trashed her bedroom and physically assaulted me."

Colleague 3 in her witness statement stated:

"I did have concerns about the cleanliness of the Home towards the end of my time working there, it was really going downhill. I recall on one occasion…the Training Manager, was in the Home and I told her to come and look in a resident's room. The resident had soiled themselves and there was faces on the wall and on the paper towel holder in their bathroom, and in their room. We had left it there because we wanted to see how long it would take for it to be cleaned. Several days had passed and the cleaners had not removed it. [Training Manager] was also shocked by this."

The panel noted that each of the witnesses highlighted deficiencies in their ability to provide care to Resident A, Resident B and Resident C. The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Colleague 1, Colleague 3 and Colleague 2.

In light of the above, the panel was satisfied that Mrs Allison admitted Residents A and/or B and/or C to the Home without ensuring that staff and/or the Home was able to meet their specialised needs

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to provide and/or ensure that an adequate standard of care was provided to the residents at the Home.

The panel therefore found Schedule C 2 of charge 4 proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;

SCHEDULE C	
3	Told a member of staff to “mind their own business” or words to that effect, when suggesting that a syringe driver be used in relation to Resident K

This charge is found proved.

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

Ms 6 in her witness statement stated:

> *“Around March 2020, I suggested to the Registrant that R:K should have Morphine and Midazolam administered through a syringe driver. This would have been more pleasant for R:K and would have only had to be changed every 12 hours instead of being injected every two hours. In my experience the use of a syringe driver is best practice and is the most up to date method used for this kind of palliative care. The Registrant told me to mind my own business and told me that staff were dealing with it.”*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 6. In light of the above, the panel was satisfied that Mrs Allison told a member of staff to “mind their own business” or words to that effect, when suggesting that a syringe driver be used in relation to Resident K.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to

provide and/or ensure that an adequate standard of care was provided to the residents at the Home.

The panel therefore found Schedule C 3 of charge 4 proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

    a) as set out in Schedule C;

SCHEDULE C	
4	Did not ensure that one, or more, members of staff were trained to provide appropriate care for Resident K
5	Did not ensure that one, or more, members of staff were trained in the use of syringe drivers and/or palliative care

This charge is found proved.

The panel considered schedule C 4 and 5 separately but as the evidence in relation to each is similar it has dealt with them under one heading.

In reaching this decision, the panel took account of the evidence of Ms 3 and Ms 6.

Ms 3 in her witness statement stated:

> *"Issue 3: Third, [Ms 6] had recommended to the Registrant that a resident, Resident K be put on a syringe driver because resent [sic] was agitated. [Ms 6] was concerned that The Registrant only responded to this request five or six weeks later. She was also concerned that other Nurses had not been trained to use a syringe driver and [Ms 6] reported that one Nurse cried because she did not know what to do. The Registrant suggested watching a YouTube video."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 3.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that one, or more, members of staff were trained to provide appropriate care for Resident K.

The panel also took account the witness statement of Ms 6 which stated:

> *"Around five or six weeks later, RiK was finally given a syringe driver. I inserted the butterfly in April 2020 on a nightshift. At handover the following morning I told the Nurse, who I cannot recall the name of, about the syringe driver. The Nurse then began to cry and told me that she did not know how to use one. She said that she had never been provided with training for syringe drivers so I asked her to call the Registrant. The Registrant came into the Home on the same day and she said that she was not happy about this on her day off. I did offer to come to the Home during the day to change the syringe driver, but the Registrant said no. Instead, she just told me to show the Nurse a YouTube video on how to use and change a syringe driver. In my opinion this would not be sufficient training. The Registrant should have arranged formal training for the Nurse as soon as possible and, in the meantime, she could have supervised the Nurse and taught her how to use it."*

Ms 3 in her witness statement stated:

> *"As part of issue 3, I separately looked into the allegation that insufficient training for staff had been given in using a syringe driver. I asked the Registrant for evidence that training had been given to the Nurses in palliative care and syringe drivers but she told me that she could not evidence this as it had not been formally done. The Registrant did, however, say that she told the Nurses to watch a YouTube video on the web. The protocols and updates from Care Inspectorate Scotland state that there should be formal training in palliative care and syringe drivers annually."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 3 or Ms 6.

The panel took account of the Investigation Report completed on 9 June 2020. It stated:

> *"d. Staff were not trained/supported to learn how to care for the syringe driver*
> *…*
> *I have asked for evidence of training or updates for staff nurses but there is no evidence of this training. HA has advised that she cannot evidence the training and that she had asked the nurse to watch the u tube video on the Web as per DNs advice…[sic]*
>
> *Outcome – HA (manager) must arrange training for all nurses on syringe driver administration and ensure they have an annual update on this process."*

In light of the above, the panel was satisfied that Mrs Allison did not ensure that one, or more, members of staff were trained in the use of syringe drivers and/or palliative care.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to provide and/or ensure that an adequate standard of care was provided to the residents at the Home.

The panel therefore found Schedule C 4 and 5 of charge 4 proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;

SCHEDULE C	
6	Admitted Resident E to the Home without enduring that staff and/or the Home was able to meet their specialised need
7	Did not ensure that one, or more, members of staff were trained to provide appropriate care for Resident E

This charge is found not proved.

The panel considered schedule C 6 and 7 separately but as the evidence in relation to each is similar it has dealt with them under one heading.

In reaching this decision, the panel took account of the evidence of Colleague 3 and Colleague 2.

Colleague 3 in her witness statement stated:

> *“Resident E was an elderly gentleman whose needs the Home could initially accommodate, but as his dementia progressed he started to exhibit very aggressive behaviours. He would wander into the rooms of other residents and wave his walking stick around, trying to hit other residents and members of staff. I suggested to the Registrant that Resident E should be moved to a specialist dementia unit for the safety of other residents, and this conversation ended in an argument. There was an incident during nightshift where I understand that Resident E attempted to thrown television out of his window. I believe that the police were called, and Resident E was admitted to the Kingsway mental health hospital in Dundee. I think that the hospital decided to section him because of the severity of his illness.”*

Colleague 2 in her witness statement stated:

> *Another resident who could be challenging was a gentleman called Resident E. He would frequently punch and kick members of staff. On one occasion when I was not on duty, he picked up a television and was trying to throw it out of the top floor window. The staff who were working that night ended up telephoning the police and I believe that Resident E was sectioned as a result. After this incident, the Registrant called me to her office and said, "What happened on Saturday night?" 1 told her that I had not been working so I did not know. She responded, "He fie Resident 7 wasn't that bad, he was alright when / saw him."I asked her what she meant by this, he had clearly been very unwell because he had tried to punch a policeman. The Registrant replied, "Yeah but sometimes certain people just inflame*

the situation" She said this very pointedly and I felt that she was trying to blame me for what had happened when I had not even been on shift. [sic]

The panel noted that Resident E's condition appeared to deteriorate and it was at this point the Home could no longer meet his specialist needs. However, according to Colleague 3 at the point of admission Resident E's needs could be accommodated and as a result appeared to be a suitable candidate for residency.

The panel reminded itself that it is for the NMC to prove the charge. In light of the above, the panel was not persuaded that Mrs Allison admitted Resident E to the Home without ensuring that staff and/or the Home was able to meet their specialised needs.

The panel also noted that it does not have any information to determine when he was accommodated which would demonstrate how long he was at the Home before his condition deteriorated. Further, the panel do not have any medical records for Resident E to determine the rate of his deterioration and subsequently when he became unsuitable for residency at the Home. Without this information, it could not establish when Mrs Allison would have needed to ensure that one, or more, members of staff were trained to provide appropriate care for Resident E.

The panel therefore found Schedule C 6 and 7 of charge 4 proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;

SCHEDULE C	
8	Did not ensure that a colleague who raised concerns relating to the case of Resident J was supported

This charge is found proved.

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

Ms 6 in her witness statement stated:

> *"I telephoned the Registrant to raise my concern that the Quinine medication was likely causing Resident Js skin reaction [sic]. She told me that I was being difficult, challenging, and rude and that the GP had prescribed it so we had to administer it. Resident J herself even asked me why she was having a skin reaction and asked me whether it was the Quinine. I had to tell Resident J that I was not sure and if she had concerns she should raise them with the Registrant. I do not know if she actually did raise these concerns… I felt that the Registrant should have supported me and at least listened to what I had said…"*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 6 who specifically stated that she felt unsupported.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to provide and/or ensure that an adequate standard of care was provided to the residents at the Home.

The panel therefore found Schedule C 8 of charge 4 proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;

SCHEDULE C	
9	Admitted Resident F to the Home without ensuring that staff and/or the Home was able to meet their specialised needs

This charge is found not proved.

In reaching this decision, the panel took account of the evidence of Colleague 1.

Colleague 1 in her witness statement stated:

> *"I cannot recall when Resident F was admitted to the Home, I believe that this was roughly Summer 2018. R was severely demented resident and I did not feel that the Home was meeting F 's needs because she was distressed and agitated all of the time. She was continuously coming out of her room, had a reduced appetite, and was very disruptive…"*

However, the panel noted that it had no information to establish what state Resident F was in at the point of admission. As a result, it could not ascertain if the Home, at the point of admission, were able to meet her specialist needs.

The panel reminded itself that it is for the NMC to prove the charge. In light of the above, the panel was not persuaded that Mrs Allison admitted Resident F to the Home without ensuring that staff and/or the Home was able to meet their specialised needs.

The panel therefore found Schedule C 9 of charge 4 not proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;

SCHEDULE C	
10	Did not ensure that the Home and/or staff were able provide appropriate care for Resident F

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 5 and Colleague 1.

Colleague 1 in her witness statement stated:

> *“I cannot recall when Resident F was admitted to the Home, I believe that this was roughly Summer 2018. R was severely demented resident and I did not feel that the Home was meeting F 's needs because she was distressed and agitated all of the time. She was continuously coming out of her room, had a reduced appetite, and was very disruptive. Within weeks of RF s admission, I told the Registrant that RF was not in the right place and that she needed a specialised placement, for example in an Elderly Mentally Infirm ("EMI") unit. The Registrant told me that "she was not going anywhere" in reference to RF On one occasion the Registrant screamed in my face "She's going nowhere!" Care staff reported to me that…the Registrant had instructed them not to complete "ABC" forms regarding RFs behaviour. These are forms that we were meant to complete to evidence RF 's stress and agitation.”*

Ms 5 in her witness statement stated:

> *Resident F was an elderly lady who had very advanced dementia. She was frequently distressed, and would scream out, "Nurse, Nurse!" When I was administering care to her, she would grab hold of my tunic and beg for help. I know that she did this to other members of staff and her conduct made it difficult for them to spend time with other residents and get on with their work. The noise that Resident F made was also distressing for the other residents. I recall that a gentleman called I whose surname I cannot now remember, tried to leave the dining room in a hurry to get away from Resident noise and he suffered a fall. There was another resident, who refused to come to the dining room for meals because of the noise.*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 5 and Colleague 1.

Colleague 1 stated that Resident F may have been admitted in the Summer 2018 and should have been transferred for specialist treatment. Therefore, so the panel was of the view that Resident F would have been at the Home for at least 18 months. During this time, it would appear that Mrs Allison did not ensure that the Home and/or staff were able provide appropriate care for Resident F.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to provide and/or ensure that an adequate standard of care was provided to the residents at the Home.

The panel therefore found Schedule C 10 of charge 4 proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

   a) as set out in Schedule C;

SCHEDULE C	
11	Did not ensure that Resident I's pain relief medication was escalated and/or reviewed timeously

This charge is found proved.

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

Ms 6 in her witness statement stated:

> *"I was on holiday for ten days. When I returned to the Home, I started my nightshift and I saw on Resident I's care notes that his medication dose was still the same and he was still crying out in pain. I spoke with the Registrant and [the Deputy Manager] again and I suggested that we put Resident I on a syringe driver. A syringe driver is a butterfly pad with a needle which can be inserted wherever*

comfortable on the body – legs, thigh, tummy or arms. It is changed every 12 hours and is used to drip medication into the patient's system. It is usually used for pain relief medication such as morphine and midazolam. When I suggested this, both the Registrant and [the Deputy Manager] completely shut the idea down and told me not to be silly."

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 6. She was the nurse on shift at the time who expressed her concerns and then reported them.

The panel bore in mind that considered the Investigation Report completed on 9 June 2020 by Ms 3, which stated:

"I can find no evidence of any mismanagement of this residents care. The last time this resident received antibiotics was the 19th November 2020. The pain relief had been reviewed by the GP on several occasions and the prescriptions changed to reflect the changing needs of the resident."

However, the panel found Ms 3 to be a credible witness whose concerns should have been taken seriously. As a result, it was satisfied that Mrs Allison did not ensure that Resident I's pain relief medication was escalated and/or reviewed timeously.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to provide and/or ensure that an adequate standard of care was provided to the residents at the Home.

The panel therefore found Schedule C 11 of charge 4 proved.

Charge 4

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

a) as set out in Schedule C;

SCHEDULE C	
12	Did not ensure that the wardrobe in Resident H's room was safe and/or attached to the wall

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Colleague 1.

Colleague 1 in her witness statement stated:

> *"In or around October 2017, I cannot recall the exact date, I was giving handover in the Home and I heard a massive crash. I went running upstairs and I saw that it was the resident Resident H who was a very obese lady. Resident H had pulled the wardrobe in her room on top of herself and she was on the floor. Luckily, the wardrobe doors had opened and Resident H was inside of the wardrobe. Resident H had no obvious injuries, however she was clearly upset and embarrassed after the incident…I had seen that there were no screws or brackets on the wall behind the wardrobe, so it was apparent to me that the wardrobe had not been attached to the wall I asked the Registrant why the wardrobe had not been attached to wall, and she responded, "it was, are you blind?'. The Registrant told me to telephone the family and tell them that the wardrobe had been screwed to the wall. I told the Registrant that I was not prepared to lie to Resident H's family. The Registrant then screamed at me to get out of her office and that she was going to do the incident report instead…"*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Colleague 1.

The panel also took account of the contemporaneous Letter from the Care Inspectorate, dated 28 May 2019, which acknowledged the concerns Colleague 1 raised about the incident.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that the wardrobe in Resident H's room was safe and/or attached to the wall.

The panel turned to the stem of the charge. It bore in mind that Mrs Allison was the Manager of the Home. It was of the view that as the Manager, she had a responsibility to provide and/or ensure that an adequate standard of care was provided to the residents at the Home.

The panel therefore found Schedule C 12 of charge 4 proved.

Charge 4b

4) Failed to provide and/or ensure that an adequate standard of care was provided to one, or more, residents:

    b) generally;

This charge is found not proved.

The panel was of the view that it could not find more examples of Mrs Allison's failure to implement updated practices/ensure following the takeover of the Home by Sanctuary Care beyond those it found proved within Schedule C.

The panel therefore found this sub-charge not proved.

Charge 5

When considering charge 5 and its schedules, the panel recognised that this occurred at the height of the coronavirus pandemic and staffing levels at the Home may have been difficult. However, despite the difficulties the Home must have faced due to covid, it considered infection control at the Home to be very important during this period.

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

a) as set out in Schedule D;

SCHEDULE D	
1	Did not ensure that the Home was in an appropriate standard of cleanliness as at the date of the inspection on 17 June 2020

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 4.

Ms 4 in her witness statement stated:

> *"On 17 June 2020 I attended an inspection of the Home…The inspection was unannounced on this occasion, meaning that staff at the Home were not aware that we were coming. The first thing we did at the Home was a "walk around" as a group so that we had a sense of the size and layout of the building and we could locate specific areas that we needed to see, for example, I knew that I had to see the laundry area so I made sure it was located during the walk around. We then separated to carry out observations and agreed to re-group an hour or so later to share findings. At inspections, we always aim to re-group frequently throughout the day, this allows us to share information and discuss any concerns or indeed aspects of excellence"*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 4.

The panel also took account of the Ms 4's typed-up copy of notes taken during inspection of 17 June 2020. Under the title "Evaluation for infection control (grade) – 1", Ms 4 has written:

> *"Levels of cleanliness in the home were unsatisfactory…"*

In light of the above, the panel was satisfied that Mrs Allison did not ensure that the Home was in an appropriate standard of cleanliness as at the date of the inspection on 17 June 2020.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 1 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

    a) as set out in Schedule D;

SCHEDULE D	
2	Did not ensure that one, or more, items of care equipment were clean and/or in repair as at the date of the inspection on 17 June 2020

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3 and Ms 4.

Ms 4 in her witness statement stated:

> *"Another area of concern for me was the state of care equipment which was generally visibly unclean. I observed that bath hoists were contaminated with faces and some pieces of equipment were in a poor state of repair. By this I mean that a piece of equipment can deteriorate so badly that it can never be cleaned effectively and would need to be replaced."*

Ms 3 in her witness statement stated:

> *"The Care Inspectorate report found the Home to be unclean. A Sanctuary Care infection control checklist was also made available for Home Managers to fill in everyday or to delegate to other staff members."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 3 and Ms 4.

The panel also took account of the Ms 4's contemporaneous handwritten notes taken during inspection of 17 June 2020.

> *"Commodes, hoist and bath hoists dirty, visibly dirty underside possibly faecal matter…" [sic]*

In light of the above, the panel was satisfied that Mrs Allison did not ensure that one, or more, items of care equipment were clean and/or in repair as at the date of the inspection on 17 June 2020.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 2 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

   a) as set out in Schedule D;

SCHEDULE D	
3	Did not ensure that cleaning duties were increased as at the date of the inspection on 17 June 2020

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 4.

Ms 4 in her witness statement stated:

> *"On the second page of my typed up notes…I observed that *cleaning duties were not increased, it is likely that they had decreased. I wrote this because I spoke to some domestic staff during the inspection and they said that there were not enough staff to get around the whole Home when cleaning. It is my view that there were just not enough domestic staff to clean a care home of this size and age. An older care home tends to have more challenging surfaces which can make cleaning more time-consuming. I also spoke to some Healthcare Assistants. It was my impression that the Healthcare Assistants at the Home were quite a good team and they did try to help with cleaning but they would not have had the same level of training as domestic staff would, and there was a concern that time spent cleaning would have a negative impact on providing personal care for residents. I did not note the names of any individuals that I spoke to during the inspection. Sometimes this is to protect their confidentiality, and sometimes this is because staff are reluctant to speak with you if you ask for their name."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 4.

The panel also took account of the Ms 4's typed-up copy of notes taken during inspection of 17 June 2020. Ms 4 has written:

> *"…Cleaning duties were not increased, it is likely that they had decreased…."*

In light of the above, the panel was satisfied that Mrs Allison did not ensure that cleaning duties were increased as at the date of the inspection on 17 June 2020.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 3 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

   a) as set out in Schedule D;

SCHEDULE D	
4	Did not ensure that there was a proper audit process was in place at the Home to ensure proper cleanliness and infection control was in place as at the date of the inspection on 17 June 2020

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 4.

Ms 4 in her witness statement stated:

> *"Every care home should have audits in place to keep track of various things. For example. I would expect a care home to have an "Infection Control Audit' in place that in some way incorporated the SICs. This could be an annual or 18 month rolling programme that allows a Home to observe and reflect on its own practices and implement improvements accordingly. When I carried out the inspection of Bridgeview Home, I took photographs of an audit document titled "Infection Control*

tool."... This tool would have been used across all care homes in the same group as Bridgeview. It is dated 17 March 2020 which is not very up to date given the context of the Covid-19 pandemic and this was an issue that I flagged...The "Infection Control Audit was not the worst audit I have seen but in my view it needed to be better organised, more aligned with the SICPs, and more up to date."

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 4.

The panel took account of the email correspondence between Ms 4 and Ms 6 at the Care Inspectorate regarding Bridgeview's "Infection Control tool" dated 18 June 2020. Ms 4 stated:

"…its worth adding that the current infection Control audit did not support the national Standards Infection Control Precautions (SICPs). The audit carried out on 17 March 2020, identified a number of concerns relation to the management of infection. No further audit despite COVID has been carried out since…"

The panel noted that Ms 4 appears to be informing Ms 6 that the standards in the infection control audit does not reach the standards required.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that there was a proper audit process was in place at the Home to ensure proper cleanliness and infection control was in place as at the date of the inspection on 17 June 2020.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 4 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

   a) as set out in Schedule D;

SCHEDULE D	
5	Did not ensure that the infection control checklist was implemented at the Home as at the date of the inspection on 17 June 2020

This charge is found proved.

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

Ms 3 in her witness statement stated:

> *"…A Sanctuary Care infection control checklist was also made available for Home Managers to fill in everyday or to delegate to other staff members…When I went into the Home I found no evidence that the Registrant had implemented this checklist…"*

The panel took account of the Sanctuary Care infection control checklist referenced in Ms 3's witness statement. It noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 3.

The panel also took account of the Completed Record of Inspection sheet for the staffing criteria. It stated:

> *"The provider did have a daily infection control checklist which should be completed twice every day. This included observation of staff practise for PPE (inc does the environment look clean and dust free/confirm with housekeeping colleagues that cleaning schedules have been followed and telephones, light switches, remote controls and doors handles cleaned)*

THIS PROCEDURE HAD NOT BEEN FOLLOWED IN [BRIDGE VIEW]"

Additionally, next to "Overall evaluation (strengths, outcomes and areas for development)" it stated:

> *"We discussed with the management team the importance of constantly supporting and reminding staff about the correct use of PPE.*
>
> *The provider had a daily infection control checklist which directed the management team to twice a day observations of staff practice wearing PPE; however, this had not been implemented at Bridge View."*

The panel was satisfied that it was Mrs Allison's duty as the Home Manager to ensure that the checklist was implemented.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that the infection control checklist was implemented at the Home as at the date of the inspection on 17 June 2020.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 5 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

   a) as set out in Schedule D;

SCHEDULE D	
6	Following an inspection on 17 June 2020, the Homes was given an inspection grade of ‘1’ in relation to Infection Prevention and Control

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 4 and Ms 5.

Ms 4 in her witness statement stated:

> *“After an inspection there is always a virtual debrief meeting which usually takes place the following day and is attended by all the individuals who carried out the inspection. At this meeting we ensure that all our notes are shared with the Care Inspectorate so that they can use it in an Inspection Report. To the best of my memory, I did see the inspection Report for Bridgeview. I do know that the Home was given an inspection grade of 1 which is the lowest grade possible out of 6. This grading system is the Care Inspectorate's so it would have been their decision, but I did give an advised grade of 1 regarding infection prevention and control. This can be seen at the end of page 7 on my typed notes…”*

Ms 5 in her witness statement stated:

> *“Additionally, the Home was issued with a letter of serious concern for infection prevention control concerns which was scored level 1 unsatisfactory and had to be remedied within 72 hours. An evaluation of 1 is the lowest that can be awarded - this is unsatisfactory, an evaluation of 6 is the highest and demonstrates practice that is excellent.”*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 4 and Ms 5.

The panel also took account of the Ms 4’s typed-up copy of notes taken during inspection of 17 June 2020. Ms 4 has written:

"Evaluation for infection control (grade) – 1"

In light of the above, the panel was satisfied that following an inspection on 17 June 2020, the Homes was given an inspection grade of '1' in relation to Infection Prevention and Control.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 6 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

   a) as set out in Schedule D;

SCHEDULE D	
7	Did not ensure that staff were given correct PPE and/or knew what guidance to follow during the Covid pandemic

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 5 and Ms 6.

Ms 5 in her witness statement stated:

"I found that the staffing performance was weak. I spoke to staff informally, and they told me that not everyone had up-to-date infection control training. Some staff members said that they found out what they knew from general public information.

I was told by some staff that that Heather had spoken to them about some aspects of Covid-19 management, but when I asked for documentation and or evidence supporting this training, the nurse on duty, whose name I cannot now recall, was unable to find any documented proof or records of training. She could not find records of training in IPC, or donning and doffing of PPE. It was particularly important that staff were competent in the safe use of PPE and donning and doffing of PPE due to the extremely high risk of infection during the COVID 19 pandemic."

Ms 6 in her witness statement stated:

"I was also very concerned over the lack of PPE. We had the usual gloves and aprons but there were no face coverings or shields or goggles available. On one occasion, the Registrant told me that if the resident does not have Covid-19 then we cannot wear any PPE. This seemed incredibly unsafe to me."

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Ms 5 and Ms 6.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that staff were given correct PPE and/or knew what guidance to follow during the Covid pandemic.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 7 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

a) as set out in Schedule D;

SCHEDULE D	
8	Did not ensure that one, or more, members off staff had up to date infection control training

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 5.

The panel took account of the completed Record of Inspection sheet for the staffing criteria provided by Ms 5. It stated:

> *"Records of staff receiving IPC training were not available. An infection control audit was carried out by the manager on 17 March 20 [sic]. Have all staff completed the mandatory infection control training/e-learning infection control module – NO*
>
> *Have all staff completed infection control training and are they aware of procedures to manage an outbreak. NO*
>
> *There was no further audit of infection control carried out. Staff we spoke with were vague about receiving this training at all and certainly not since C19."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the evidence from Ms 5.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that one, or more, members of staff had up to date infection control training.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 8 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

   a) as set out in Schedule D;

SCHEDULE D	
9	Did not ensure that the Home followed the proper process for disposal of clinical waste

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 4.

The panel also took account of the Ms 4's typed-up copy of notes taken during inspection of 17 June 2020. Ms 4 has written:

> *"Is infectious waste disposed of through a clinical waste stream, does the organisation have a clinical waste contract?*
>
> *NO, this remained an area of concerns. PPE was almost always disposed of in general bins. There had been clinical bins in place however these had been removed as guidance had been misinterpreted. There was a clinical waste contact in place which had been changed to another provider on the day of inspection. We noted clinical bins to be locked and almost empty. Bins only need to be locked when they are full. Locking the bins could have been a deterrent for staff disposing of PPE safely. We understand the notion was to prevent harm to passers-by."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the evidence from Ms 4.

In light of the above, the panel was satisfied that Mrs Allison did not ensure that the Home followed the proper process for disposal of clinical waste.

The panel turned to the stem of the charge. The panel bore in mind that while Mrs Allison was not present at the Home between the meeting with management on 15 June 2020 and her resignation on 22 June 2020. However, it was of the view that as the Manager, she had a responsibility to adopt and/or ensure that proper infection control measures were implemented at the Home.

The panel therefore found Schedule D 9 of charge 5 proved.

Charge 5

5) Failed to adopt and/or ensure that proper infection control measures were implemented at the Home:

   b) generally;

The panel found this sub-charge not proved

The panel was of the view that it could not find more examples of Mrs Allison's failure to implement updated practices/ensure following the takeover of the Home by Sanctuary Care beyond those it found proved within Schedule A.

The panel therefore found this sub-charge not proved.

Charge 6

6. Behaved in the manner set out in Schedule E

SCHEDULE E	
1	From in, or around, Summer 2018, said to Colleague 1, "You are not doing your job properly" or words to that effect
2	In, or around, October 2018, said to Colleague 1, "You don't; want to mess with me because you know I can destroy you" or words to that effect

3	In, or around, November 2018, said to Colleague 1, “Do you have something to tell me” or words to that effect when asking about an alternative job
4	At, or around, the end of November 2018, contacted/e-mailed a prospective employer of Colleague 1 and informed them that Colleague would not take up a job with the prospective employer
5	On one, or more, occasions, threw communication at Colleague 1, when being asked to approve an “off duty” request
6	On one or more, occasion, shouted at Colleague 1
7	On one, or more, occasion pointed in Colleague 1’s face

The panel found Schedule E 1-7 proved.

The panel considered each of these individual schedules separately but as the evidence in relation to each comes from Colleague 1, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague 1.

With regards to schedule E 1, Colleague 1 in her witness statement stated:

> *“From Summer 2018, certain behaviours of the Registrant started to concern me more and ultimately I felt like I was bullied by the Registrant. For example she would walk past me and make belittling comments such as, "You are not doing your job properly". I recall one particular occasion she said this to me after I had had a meeting with a Community Psychiatric Nurse, whose name I cannot now recall, and [Ms 10], the Operational Manager, about Resident F The Registrant then carried on walking past me.”*

With regards to schedule E 2, Colleague 1 in her witness statement stated:

> *“There was another occasion when the Registrant said to me "You don't want to mess with me because you know I can destroy you". I cannot recall exactly when the Registrant said this, I would guess it was around October 2018. This really scared me and I thought I needed to get out of the .” [sic]*

With regards to schedule E 3 and 4, Colleague 1 in her witness statement stated:

“By this point I was terrified of the Registrant but I knew that the Registrant would be asked for a reference. On one occasion soon after my interview at MoynessNursing Home [sic], the Registrant was on the same shift as me and she came to the Nurses' station and closed the door and said "Do you have something to tell me? She then asked about the iob at Moyness. I replied to say that I had not decided yet. I then telephoned Moyness to find out about the job and was told by them that the Registrant had emailed them and told them that was not going to take the job. This was untrue. This happened around the end of November 2018.”

With regards to schedule E 5, Colleague 1 in her witness statement stated:

“When I would go into the Registrant's office and ask for the off-duty, she would throw it at me and not hand it to me. This happened all of the time. I eventually stopped asking the Registrant for the off-duty and I asked another member of staff for example to go and get it.”

With regards to schedule E 6, Colleague 1 in her witness statement stated:

“I had seen that there were no screws or brackets on the wall behind the wardrobe, so it was apparent to me that the wardrobe had not been attached to the wall. I asked the Registrant why the wardrobe had not been attached to wall, and she responded, "it was, are you blind?" The Registrant told me to telephone the family and tell them that the wardrobe had been screwed to the wall. I told the Registrant that I was not prepared to lie to Resident Hs family. The Registrant then screamed at me to get out of her office and that she was going to do the incident report instead...

…I cannot recall where Resident F was admitted to the Home, I believe that this was roughly Summer 2018. RF was severely demented resident and I did not feel that the Home was meeting RF 's needs because she was distressed and agitated all of the time…I told the Registrant that RF was not in the right place and that she needed a specialised placement, for example in an Elderly Mentally Infirm ("EMI") unit. The Registrant told me that "she was not going anywhere in reference to RF On one occasion the Registrant screamed in my face "She's going nowhere!"…”

With regards to schedule E 7, Colleague 1 in her witness statement stated:

> *“The Registrant had a particularly close relationship with R:A and allowed her to call the Registrant 'Mum". This happened daily. If R: A did not get her way with a member of staff she would point her finger in their face and say, "I'm telling mum on you. 'The day that R:A trashed her bedroom and assaulted me, several police officers and a GP attended the scene. After everything had calmed down, the Registrant sat beside R:As bed for a long period of time stroking her hair.”*

The panel noted the escalation of distress of Colleague 1. It noted the involvement of the operations manager who Colleague 1, in her witness statement, stated was due to investigate her concerns. It further noted the subsequent involvement of Colleague 1’s union representative. Colleague 1 stated, in her witness statement, that a union meeting was held on 22 May 2019 because nothing had been done regarding Colleague 1’s concerns. The panel also took account of Colleague 1’s resignation letter, dated 27 May 2019 sent to Mrs Allison.

The panel noted particularly the Statement of Concerns, sent to Mr 9 on 14 April 2019, written by Colleague 1 and two other nurses which described Mrs Allison’s anger and volatile behaviour.

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the evidence from Colleague 1.

As a result, in the absence of evidence from Mrs Allison to contradict the evidence of Colleague 1, the panel was of the view that Mrs Allison behaved in the manner set out in Schedule E 1 to 7.

The panel therefore found Schedule E 1 to 7 of charge 6 proved.

Charge 6

6. Behaved in the manner set out in Schedule E

SCHEDULE E	
8	On an unknown date, screamed and/or shouted at Colleague 2 when discussing Resident E
9	On an unknown date, pointed your finger close to Colleague 2's face when discussing Resident E

The panel found Schedule E 8 and 9 proved.

The panel considered each of these individual schedules separately but as the evidence in relation to each comes from Colleague 2, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague 2 and Ms 7.

Colleague 2 in her witness statement stated:

> *"[Ms 7], the Home Administrator, had witnessed the Registrant shouting and pointing in my face. I knew that she had telephoned the police about Residents A aggression and she had cried to me about Residents E trying to hit her with his stick. However, when the internal investigation arose, she completely backtracked and had nothing bad to say about the Registrant's management. This really surprised me. I also believe that the internal investigation may have been affected by the fact that [the Operations Manager] was friends with the Registrant. I knew this because the Registrant would make comments like, " was speaking with [the Operations Manager] last night on the phone" and I do not think they would have had telephone calls out of hours unless they were friends socially."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Colleague 2.

The panel bore in mind that Ms 7 stated:

"I have been asked whether I was aware of any complaints from members of staff regarding the Registrant's management. There were no complaints that I can recall."

However, the panel preferred the evidence of Colleague 2. As a result, the panel was of the view that Mrs Allison behaved in the manner set out in Schedule E 8 and 9.

The panel therefore found Schedule E 8 and 9 of charge 6 proved.

Decision to amend the charge

When considering the evidence of charge 6, the identity of the colleague referred to in Schedule E 10 and 11 was clear to the panel as it would have been to Mrs Allison. However, following the anonymisation of the colleagues, that person is incorrectly referred to as Colleague 4 in the schedules when in fact it was Colleague 3.

In those circumstances, the panel consider that the references to Colleague 4 in those sub charges could be corrected to refer to Colleague 3 without any resulting injustice. The proposed amendment would provide clarity and more accurately reflect the evidence.

Amended charge

6. Behaved in the manner set out in Schedule E

SCHEDULE E	
10	On an unknown date, stated word to the effect of "this is ridiculous, if I was working with HC-One we would have sacked her" when referring to ~~Colleague 4~~ Colleague 3
11	On an unknown date, contacted a prospective employer of ~~Colleague 4~~ Colleague 3 and stated that they were unemployable, or words to that effect

Charge 6

6. Behaved in the manner set out in Schedule E

SCHEDULE E	
10	On an unknown date, stated word to the effect of “this is ridiculous, if I was working with HC-One we would have sacked her” when referring to Colleague 3
11	On an unknown date, contacted a prospective employer of Colleague 3 and stated that they were unemployable, or words to that effect
12	On one, or more occasion, said the you wanted Colleague 5 “gone”, or words to that effect
13	On an unknown date, shoved Colleague 6 in the back

The panel found Schedule E 10 to 13 proved.

The panel considered each of these individual schedules separately but as the evidence in relation to each mostly comes from Colleague 1, it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague 1, Colleague 3 and Ms 7.

With regards to Schedule E 10, Colleague 1 in her witness statement stated:

> *“The Registrant suspended [Colleague 3]. It was my perception that the Registrant was not interested in the rationale for not giving this resident a biscuit, but was using the incident as an excuse to get rid of a career that she disliked. [Colleague 3] challenged the suspension and I attended a meeting with [Colleague 3], her Union representative…, and the Registrant. When there was any kind of employment issue, the Home would seek advice from a company called Citation and I believe that Citation advised that [Colleague 3] should not be dismissed. I recall that the Registrant was annoyed about this outcome. She made a comment to me to the effect of, "his is ridiculous, if I was working with HC-One we would have sacked her".*

With regards to Schedule E 11, Colleague 1 in her witness statement stated:

> *“[Colleague 3] did end up leaving and accepting a job at a care home called Clement Park. She asked me to give her a reference, and I was happy to do so because I found her pleasant and the residents she worked with were always well*

cared for. I received a telephone call from the Home Manager at Clement Park, I cannot now recall her name. This manager told me that she had been telephoned by the Registrant, and informed that [Colleague 3] was unemployable. The manager said that this contrasted with my reference and with what she had experienced with [Colleague 3] so far."

The panel also noted that Colleague 3 stated:

"I handed in my notice at Bridge View towards the end of 2019. The Registrant was the only reason I decided to leave, I could no longer work at the Home while she was the Manager. Within a week I managed to get a new job at Clement Park Care Home. I told the Manager…all about my experience at Bridge View and she was very nice and offered me the position. A week later I had to go into Clement Park Care Home for a moving and handling course before my official start date. That day, [the Manager] asked me to come to her office before I left. She told me that she had received a telephone call from the Registrant who had said that I was unemployable."

With regards to Schedule E 12, Colleague 1 in her witness statement stated:

"[Colleague 5] was another Care Assistant and the Registrant would make comments to me that she wanted [Colleague 5] gone. I believe that one of the reasons the Registrant did not like [Colleague 5] was that she was on a contract whereby she did 8 night shifts in a row and then had a period of time off. The Registrant was eager to implement a new "rolling rota" that would pre-assign shifts for each coming week, and [Colleague 5]'s contract did not fit in well with this arrangement."

With regards to Schedule E 13, Colleague 1 in her witness statement stated:

"[Colleague 6] was a Staff Nurse at the Home. One evening, she telephoned me when I was at home and she was in a very distressed state, she was in tears. She told me that a GP had come in to the Home to visit a resident and she, the Registrant, and the GP were walking down the corridor to a resident's room with the

GP leading the way. According to [Colleague 6], the Registrant shoved her in the back. She turned around and saw the Registrant had a very angry expression on her face and was in a foul mood for the whole of that shift…

…However, it is my belief that the investigation was affected by certain members of staff being terrified of the Registrant's reaction. [Colleague 6] had telephoned me in tears about the Registrant shoving her in the corridor and she had reported the incident…. However, suddenly she retracted her statement and she was then on annual leave which I knew she should not have been entitled to take, because she had used up her allowance. I found this to be suspicious."

The panel also took account of the Statement of Concerns dated 14 April 2019. The panel bore in mind that this is hearsay but supports what has been said in the witness statement. On that basis, the panel was of the view that it was fair to accept it as evidence.

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statements from Colleague 1, Colleague 3 and Ms 7.

As a result, in the absence of evidence from Mrs Allison to contradict the evidence of Ms , the panel was of the view that Mrs Allison behaved in the manner set out in Schedule E 10 to 14.

The panel therefore found Schedule E 10 to 14 of charge 6 proved.

Charge 6

6. Behaved in the manner set out in Schedule E

SCHEDULE E	
14	On an unknown date said to Colleague 3, "Your colleagues don't like working with you and they don't think you are good at your job", or words to that effect

This charge is found proved.

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

Colleague 3 in her witness statement stated:

> *"I came into work a few nights later and I was asked to go and speak to the Registrant in her office. She informed me that [Ms 8] had told her that I had shouted at her and Resident G…The Registrant also told me that she had a signed statement from [Colleague 5], another Carer, confirming that I had shouted at Residents. The Registrant said to me, "Your colleagues don't like working with you and they don't think you are good at your job". I responded, "I know that's rubbish and so do you so let's leave it there".*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Colleague 3.

As a result, in the absence of evidence from Mrs Allison to contradict the evidence of Colleague 3, the panel was of the view that Mrs Allison behaved in the manner set out in Schedule E 14.

The panel therefore found Schedule E 14 of charge 6 proved.

Charge 6

6. Behaved in the manner set out in Schedule E

SCHEDULE E	
15	On an unknown date said to Colleague 3, "Don't ignore me [Colleague 3]", or words to that effect

This charge is found proved.

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

Colleague 3 in her witness statement stated:

> *"As a result of the disciplinary, I was put on day shifts for a period of time. This meant that I saw the Registrant more regularly so I tried to stay out of her way as I felt there had been a breakdown in our professional relationship. On one occasion, the Registrant walked up to me in the corridor and was so close to my face that she was actually bent down. She whispered, "Don't ignore me [Colleague 3]n", as though she was trying to provoke me. I do not believe that I said anything in response, I just walked away. No one else was there to witness this incident."*

The panel noted that it had no written representations from Mrs Allison in response to the charge. Further, it had no reason to doubt the veracity of the witness statement from Colleague 3.

As a result, in the absence of evidence from Mrs Allison to contradict the evidence of Colleague 3, the panel was of the view that Mrs Allison behaved in the manner set out in Schedule E 15.

The panel therefore found Schedule E 11 of charge 6 proved.

Charge 6

6. Behaved in the manner set out in Schedule E

SCHEDULE E	
16	In, or around, the end of 2019, contacted a prospective employer of Colleague 3 and stated that they were unemployable, or words to that effect

This charge is amended by deletion

The panel noted that charge 6 Schedule 16 is a duplicate of charge 6 Schedule 11. The panel has already found 6 Schedule 11 proved. Accordingly, the panel concluded that this charge should be deleted.

Charge 7

7. Failed to maintain professional boundaries with Resident A, as set out in Schedule F

SCHEDULE F	
1	Permitted and/or allowed Resident A to call you “mum” and/or “work mum”
2	Gave Resident A, a photograph of yourself
3	On one, or more, occasion, made comments about taking Resident A to you house for the weekend
4	Instructed one, or more, members of staff to take Resident A to a restaurant and/or buy Resident A a toy, when the resident had behaved in a challenging or aggressive manner
5	On one, or more, occasion, said you wanted to take Resident A and/or their sibling(s) home
6	Cuddled and/or stroked Resident A’s hair
7	Gave Resident A, and their sibling, a present when you returned from leave
8	Following Resident A having been moved to alternative accommodation, said to Colleague 1 and /or Colleague 2, that they had “overstepped the mark”, or words to that effect

The panel found Schedule F 1 to 8 proved.

The panel considered each of these individual schedules separately but as the evidence in relation to each mostly comes from Colleague 1, Colleague 2 and Colleague 3 with no response from Mrs Allison it has dealt with them under one heading. In reaching this decision, the panel took account of the evidence of Colleague 1, Colleague 2 and Colleague 3.

With regards to Schedule F 1, Colleague 3 in her witness statement stated:

> *“…one girl who was around 20 years old had mental capacity, but was physically disabled, and the other girl and boy who were both 16 or 17, had severe learning difficulties. The girl with learning difficulties had very challenging behaviour. She*

was often running around the Home which was disruptive to the other residents. The Registrant allowed this young person to call her "mum". For example, she would refuse to take a bath or a shower in the morning and say, "mum says I don't have to, " in reference to the Registrant."

The panel also noted that Colleague 1 stated:

"The Registrant had a particularly close relationship with R:A and allowed her to call the Registrant 'Mum". This happened daily. If R:A did not get her way with a member of staff she would point her finger in their face and say, "I'm telling mum on you. [si]c] 'The day that R:A trashed her bedroom and assaulted me, several police officers and a GP attended the scene. After everything had calmed down, the Registrant sat beside R:As bed for a long period of time stroking her hair."

The panel further noted that Colleague 2 stated:

"I perceived that the Registrant had an inappropriate relationship with Resident A. She allowed Resident A to call her "mum". At first I thought that this was a joke and that the Registrant was just playing along that she was a "work mum" but I think I was trying to rationalise what was happening because it was so bizarre…Heather implied to the Learning Disability Team that Resident A had come up with the "mum" references by herself but I am confident that Resident would not have had the capacity to do this without the Registrant's encouragement."

With regards to Schedule F 2 and F 3, Colleague 2 in her witness statement stated:

"…*The Registrant gave Resident A a photograph of herself to keep in her room and she made frequent comments to me about taking Resident to her house for the weekend…"*

With regards to Schedule F 3, Colleague 1 in her witness statement stated:

"It is my view that the Registrant did not maintain appropriate and professional boundaries with Resident A, B,C When staff reported struggling to manage any of

the siblings, the Registrant would dismiss their concerns and make comments like, "/ want to adopt them and take them home".

With regards to Schedule F 4, Colleague 2 in her witness statement stated:

“On occasions where Resident A was being challenging or aggressive, the Registrant would take £40 out of the Home's kitty and instruct a Carer to take Resident A out into town and buy her a toy, or take her to McDonalds. It was unprofessional and seemed to be rewarding, Resident A for bad behaviour.”

With regards to Schedule F 5, Colleague 1 in her witness statement stated:

“It is my view that the Registrant did not maintain appropriate and professional boundaries with Resident A, B, C. When staff reported struggling to manage any of the siblings, the Registrant would dismiss their concerns and make comments like, "I want to adopt them and take them home". The Registrant used to say this to me on a regular basis.”

The panel were mindful that there could be an element of duplication with regards to schedule F 3 and 5. While the panel noted that the evidence supporting schedule F 3 and 5, come from two different witnesses, it was of the view that they could both be talking about the same incident.

With regards to Schedule F 6, Colleague 1 in her witness statement stated:

“The day that R:A trashed her bedroom and assaulted me, several police officers and a GP attended the scene. After everything had calmed down, the Registrant sat beside R:As bed for a long period of time stroking her hair.”

With regards to Schedule F 7, Colleague 1 in her witness statement stated:

“On one occasion, when the Registrant returned from a holiday in Florida, she brought back presents for R:A and. Resident C and no-one else.”

With regards to Schedule F 8, Colleague 1 in her witness statement stated:

> *"[Mr 9] informed me that he had told the Registrant to take a day off and not say goodbye to Resident A when she left because he felt it would be distressing for R:A. The Registrant came back shortly after R:A was placed in a different setting and she was very angry with me and [Colleague 2]. She told me that [Colleague 2] and I had overstepped the mark."*

The panel noted that it had no written representations from Mrs Allison in response to any of these charges. Further, it had no reason to doubt the veracity of the witness statement from Colleague 1, Colleague 2 and Colleague 3.

In light of the above, the panel was satisfied that Mrs Allison failed to maintain professional boundaries with Resident A, as set out in Schedule F in its entirety.

The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Allison'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 Allison's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as:

> *'[331B-E] Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rule and standards ordinarily required to be followed by a [nurse] practitioner in the particular circumstances'.*

In its written submissions, the NMC invited the panel to take the view that the facts found proved amount to misconduct and provided provisions of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") which, in the NMC's view, Mrs Allison had breached.

The NMC submitted that the misconduct is serious because of Mrs Allison's actions breaching multiple fundamental tenets of the profession, such as professionalism, trust and a duty to preserve the safety of patients. The NMC further submitted that the concerns raised are wide-ranging, longstanding, had the potential for serious, unwarranted patient harm, demonstrates a significant underlying attitudinal issue, and fall far below the standards expected of a registered professional.

In relation to impairment, the NMC asked the panel to bear in mind its overarching objective to protect 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. The NMC referred the panel to the questions outlined by Dame Janet Smith in the 5th Shipman Report (as endorsed in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)),* namely:

i) has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or

ii) has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or

iii) has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future and/or

iv) has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future

The NMC invited the panel to find the first three limbs of the test engaged. The NMC submitted that Mrs Allison has failed to demonstrate any insight and has not undertaken any relevant training. In light of this, the NMC invited the panel to find that there is a risk a repetition at this time and therefore it should be concluded that Mrs Allison's fitness to practice is impaired on public protection grounds. The NMC further submitted that Mrs Allison's actions are also so serious that a finding of current impairment is required in order to maintain public confidence in the professions and to uphold proper professional standards.

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

Decision and reasons on misconduct

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

In relation to charge 1, the panel determined that Mrs Allison's actions breached the following provisions of the Code:

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

To achieve this, you must:

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

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

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

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

10.5 …

10.6 collect, treat and store all data and research findings appropriately"

In relation to charge 2, the panel determined that Mrs Allison's actions breached the following provisions of the Code:

"6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 …

6.2 maintain the knowledge and skills you need for safe and effective practice"

And,

"22 Fulfil all registration requirements

To achieve this, you must:

…

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance"

In relation to charge 4, the panel determined that Mrs Allison's actions breached the following provisions of the Code:

"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

…

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

And,

"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

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

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

In relation to charge 5, the panel determined that Mrs Allison's actions breached the following provisions of the Code:

"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)

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

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

In relation to charge 6, the panel determined that Mrs Allison's actions breached the following provisions of the Code:

"1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion"

And,

"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

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

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

20.4 …

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 …

20.7 …

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.9 …

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times"

In relation to charge 7, the panel determined that Mrs Allison's actions breached the following provisions of the Code:

"20 Uphold the reputation of your profession at all times

To achieve this, you must:

…

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

In light of these findings, the panel determined that the concerns raised in Mrs Allison's case are wide-ranging, longstanding, had the potential for serious, unwarranted patient harm and fell far below the standards expected of a registered professional. It further determined that some of Mrs Allison's actions are indicative of an underlying attitudinal issues. The panel therefore concluded that Mrs Allison's actions, which led to the charges, amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Allison'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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:*
>
> *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 was of the view that patients were put at an unwarranted risk of harm as a result of Mrs Allison's misconduct. The panel determined that Mrs Allison's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its

reputation into disrepute. The panel accepted that the Covid – 19 pandemic may have been a stressful period for Mrs Allison. It was a particularly difficult time for everyone, especially those in the health care profession. However, it determined that during this time, the importance of adhering and implementing appropriate policies and standards would have been heightened, particularly when having regard to the vulnerable cohort of patients in her care.

The panel then went on to consider the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin). Whilst the panel accepted that it is inherently more difficult to remediate the underlying attitudinal issues identified, it determined that the misconduct found in Mrs Allison's case is capable of remediation. However, the panel noted that Mrs Allison's is not currently practising as a registered nurse and further, it did not have before it any evidence of remediation completed by Mrs Allison to suggest that she has strengthened her practice and/or taken steps to address the misconduct identified.

Further, the panel did not have any evidence before it to suggest that Mrs Allison has sought to demonstrate any insight into her misconduct. To the contrary, Mrs Allison has failed to engage with the NMC, her regulator, throughout these proceedings. In the absence of any remediation and/or insight, the panel determined that there is a continuing risk to the public and therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. It was of the view that a well-informed member of the public would be concerned if a finding of impairment were not made in respect of a nurse whose actions are so serious and wide ranging.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Allison off the register.

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

Representations on sanction

In its written submissions, the NMC invited the panel to consider imposing a striking off order in order to appropriately mark the seriousness of the concerns, protect the public and maintain trust and confidence in the profession.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The wide ranging, repeated and sustained nature of the misconduct;
- The underlying attitudinal issues identified;
- Mrs Allison's lack of insight into her misconduct;
- The absence of any remediation; and

- At the time the charges arose, Mrs Allison was in a position of trust as the manager of the Home.

The panel also took into account the following mitigating features:

- Some of the charges arose during a highly demanding period during the Covid – 19 pandemic.

The panel first considered whether to take no further 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 Allison's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Allison's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Allison's registration would be a sufficient and appropriate response. The panel noted that in Mrs Allison's case, there are some clinical aspects of her practice which could be addressed by way of a conditions of practice order. However, the panel did not have any evidence before it to suggest that Mrs Allison would be willing to comply with such an order, given her non engagement with her regulator and the underlying attitudinal issues identified. Further, it has been indicated by Mrs Allison that she does not intend to return to nursing practise and the panel have not received any information to indicate that she has kept up to date with relevant nursing training. The panel therefore determined that the placing of conditions on Mrs Allison's registration would not be workable or adequately address the seriousness of this case and would not protect the public.

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

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

The panel considered the fact that Mrs Allison's case does not relate to a single instance of misconduct, but rather a prolonged period of repeated failures, indicating an underlying attitudinal issues. Further, the panel did not have any evidence of remediation and/or insight demonstrated by Mrs Allison, and therefore could not be satisfied that the misconduct found proved would not be repeated. The panel was of the view that Mrs Allison's behaviour contributed to a culture that suppressed openness about the safety of care and presented a real risk of patient care being affected. The panel therefore determined that Mrs Allison's conduct, as highlighted by the facts found proved could not be satisfactorily addressed by way of a suspension order and concluded that such an order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel was of the view that the findings in this particular case demonstrate that Mrs Allison's actions were serious and to allow her to continue practising would undermine

public confidence in the profession and in the NMC as a regulatory body. Mrs Allison's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register.

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

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

This will be confirmed to Mrs Allison in writing.

Interim order

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

Representations on interim order

In its written submissions, the NMC invited the panel to impose an 18 months interim suspension order on both public protection and public interest grounds.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to allow for the possibility of an appeal.

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

That concludes this determination.