Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 7 August 2023 – Thursday 10 August 2023
Monday 14 August 2023 – Friday 25 August 2023
Monday 8 January 2024 – Friday 12 January 2024

Virtual Hearing

Name of Registrant:	**Joanne Marie King**
NMC PIN	79L0344E
Part(s) of the register:	Registered Nurse (Sub Part 1) Adult Nursing Level 1 – 29 October 1998 Registered Nurse (Sub Part 2) Adult Nursing Level 2 – 21 November 1980
Relevant Location:	Yorkshire
Type of case:	Misconduct
Panel members:	Rachel Onikosi (Chair, Lay member) Tracey Chamberlain (Registrant member) David Anderson (Lay member)
Legal Assessor:	Attracta Wilson
Hearings Coordinator:	Zahra Khan
Nursing and Midwifery Council:	Represented by Claire Stevenson, Case Presenter
Miss King:	Present and not represented at the hearing
Facts proved by admission:	Charges 2c and 2d
Offer no evidence:	Charges 5a, 5b, 5c, 5d, and 10
No case to answer:	Charges 1d, 5e and 7

Facts proved:	Charges 1a, 1b, 2a, 2b, 4a, 4b, 8, 9 and 12
Facts not proved:	Charges 1c, 1e, 1f, 1g, 1h, 2e, 3a, 3b, 4c, 6, 11a and 11b
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Details of charge

That you, a Registered Nurse, whilst employed as the Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that:

1. In respect of Resident A:

a) You did not ensure his dietary requirements and/or food supplementation and/or fluid intake was being adequately identified and managed

b) You did not ensure that an adequate standard of record keeping was being maintained in respect of his clinical records

c) You did not ensure that adequate documentation was maintained in respect of consent and/or mental capacity assessments that had taken place

d) There was no record in his care plan of an application being made to North Yorkshire County Council ("NYCC") in respect of a deprivation of liberty safeguard, namely the use of a sensor mat

e) You did not ensure his care plan contained a proper assessment as to his ability to consent to care and treatment

f) You did not ensure that correct medication patches were being applied properly by staff and/or changes were being made in line with prescribing instructions

g) You did not ensure that staff adhered to safe medication administration, in that they observed that medication had been safely ingested

h) You did not ensure that staff promptly undertook testing for signs of a [PRIVATE] which resulted in a delay in Patient A receiving antibiotics

2. In respect of Resident B:

a) You did not ensure that an adequate standard of record keeping was being maintained in respect of his clinical records

b) You did not ensure that his dietary requirements and/or fluid intake was being adequately identified and managed

c) Following a falls risk assessment which placed him in the higher risk category, you did not ensure that written guidance was provided to staff on how to manage and reduce the risk of him falling

d) Following a nutritional assessment which placed him in the higher risk category, you did not ensure that a risk management plan was put in place in respect of his nutritional and hydration needs

e) You did not ensure that there was a formal assessment of his mental capacity contained in his care records

3. In respect of Resident C:

a) You did not ensure that an adequate standard of record keeping was being maintained in respect of his clinical records

b) You did not ensure that clinical records adequately recorded what action had been taken between February and March 2016 to treat his wound

4. On 14 July 2016, you failed to ensure that Resident B was being adequately cared for by staff in that:

a) He was lying in faeces and urine

b) His clinical documentation had not been completed in over four hours

c) When notified by Person B of his presenting condition, you did not ensure that he was promptly seen and/or assessed

5. On 25 April 2016 you failed to ensure that the care needs of residents were being met by staff in that:

a) In respect of an unknown patient who was located in a room with an ant infestation on the bedside table, you did not ensure that he was moved to another room

b) In respect of the same unknown patient referenced at charge 5a) above you inappropriately said to Person A: “I’ve told the staff to leave him there because he’s a dirty man”

c) In respect of an unknown patient who was covered in urine you did not ensure that he/she was promptly reviewed and/or changed

d) In respect of the same unknown patient referenced at charge 5c) above, you did not ensure that his/her bed sores, pressure sores and skin integrity was of an acceptable standard

e) In respect of Resident A, you did not ensure that an adequate standard of cleanliness and/or infection control was being maintained in Resident A’s room

in that it was covered in faeces

6. You did not carry out regular audits of clinical records to ensure they were being completed by staff to an adequate standard

7. You did not ensure that staffing levels were sufficient at the Home to ensure that all residents care needs were being met

8. You did not ensure that staff were up to date with their mandatory training and/or that staff supervisions were being carried out

9. You did not ensure that new starters undertook appropriate training soon after commencement of their employment

10.You did not ensure that medication was being stored securely in the medication trolley

11.You inappropriately admitted the following residents to the Home when an assessment of suitability had not been carried out and/or a care contract was not in place:

a) Resident E
b) Resident XXX

12.You did not fully engage with safeguarding procedures when raised by North Yorkshire County Council (NYCC")

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

Background

The concerns underpinning the charges arose whilst you were employed as the manager and a registered nurse of Sowerby House ('the Home') from 29 June 2015 to 15 July 2016. You were the Care Quality Commission (CQC) Registered Manager of the Home from 5 January 2016 to 15 July 2016. You resigned from your employment at the Home with immediate effect on 15 July 2016. The CQC authorised removal of your Registered Manager registration on your own application on 25 November 2016.

The Home is owned by Larchwood Care Homes (North) Limited and was registered with the CQC on 30 September 2011. The conditions attached to that registration approved the provision of nursing and personal care for up to 51 service users which included older people and people living with dementia. Larchwood Care Homes (North) Limited operates 20 other care homes in England.

The concerns raised relate to your alleged failure to effectively manage Sowerby House between 29 June 2015 and 15 July 2016.

The Home was not inspected by the CQC during your time as Registered Manager. Prior to you becoming the Registered Manager, the Home was inspected on 19 February 2015 and 8 April 2015. It had been given an overall rating of "good" at that time. After you resigned as the Registered Manager, the Home was inspected on 13 October 2016, 14 October 2016 and 19 October 2016. It was given an overall rating of "inadequate" at that time.

The inspection in October 2016 was unannounced and came about in part because the CQC was notified of concerns about [PRIVATE]. However, potential concerns about nutrition and hydration as well as general standards of care were identified, and the CQC inspection examined those issues.

The inspectors identified regulatory breaches in six areas under the Regulated Activities Regulations 2014. These were failures in relation to consent under the Mental Capacity Act, the provision of safe care and treatment, safeguarding service users from abuse, nutritional and hydration care, governance of the home and staffing.

On the third and final day of the inspection on 19 October 2016 inspectors identified concerns regarding Resident C who was funded for residential care only. These included the monitoring and management of Resident C 's [PRIVATE] and blood sugar levels together with the service having run out of prescription dressings [PRIVATE]. Inspectors raised these findings as a safeguarding alert to the North Yorkshire Local Authority (NYLA) safeguarding team and Resident C was urgently reassessed as requiring nursing care.

The CQC had "concerns" about your competence as Registered Manager, and they were clear with the Registered Provider that if they (the Registered Provider) had not referred you to the NMC, the CQC would have done so.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Stevenson, on behalf of the Nursing and Midwifery Council NMC, to amend the wording of charge 1g to correct a typographical error and the stem of charge 4, and charges 1b, 2a, 3a, 3b, 4b, and 6 to remove the reference to "clinical", as well as correcting the introduction to the charge by amending your employment position.

The proposed amendment in relation to charge 1g was to correct a typographical error, and in relation to charges 1b, 2a, 3a, 3b, 4b, and 6 was to apply the charges to all records rather than just clinical records. The proposed amendment in relation to charge 4 was to reflect the dates more accurately. It was submitted by Ms Stevenson that the proposed amendments would provide clarity, more accurately reflect the evidence, would cause no unfairness to you and would be in the interests of justice. In relation to charges 1b, 2a, 3a, 3b, 4b, and 6, Ms Stevenson submitted that the removal of the word 'clinical' would not affect the mischief to be addressed by the charges.

*"That you, a Registered Nurse, whilst employed as the **Home Manager /** Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that:*

1. In respect of Resident A:

b) You did not ensure that an adequate standard of record keeping was being maintained in respect of his ~~clinical~~ records

g) You did not ensure that staff adhered to safe medication administration, in that they **did not observe** ~~observed~~ that medication had been safely ingested

2. In respect of Resident B:

a) You did not ensure that an adequate standard of record keeping was being maintained in respect of his ~~clinical~~ records

3. In respect of Resident C:

a) You did not ensure that an adequate standard of record keeping was being maintained in respect of his ~~clinical~~ records

b) You did not ensure that ~~clinical~~ records adequately recorded what action had been taken between February and March 2016 to treat his wound

4. On **or around** 14 July 2016, you failed to ensure that Resident B was being adequately cared for by staff in that:

b) His ~~clinical~~ documentation had not been completed in over four hours

6. You did not carry out regular audits of ~~clinical~~ records to ensure they were being completed by staff to an adequate standard

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

You had no objections to the proposed amendment, and you agreed that the amendments did not alter the substance of the charges. In respect of charges 1b, 2a, 3a, 3b, 4b, and 6, you indicated "records are records".

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004' (the Rules).

The panel was of the view that to allow the amendments, the subject of the application would be in the interest of justice, would cause no unfairness to you, would properly address the mischief in the charges and would provide clarity. The panel therefore determined to allow all amendments applied for.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Stevenson under Rule 31 of the Rules to allow the written statement Person A dated 20 March 2018 to be admitted into evidence as hearsay. Person A at the relevant time was an Agency Nurse and she worked part of a shift with you on 25 April 2016. The panel was provided with a copy of Person A's police witness statement dated 1 December 2016. Person A was not present at this hearing and, whilst the NMC had made efforts to secure Person's A's attendance, she was unable to attend for [PRIVATE]. A certificate from [PRIVATE] was provided to the panel supporting the reasons given for being absent.

Ms Stevenson submitted that part of Person A's evidence may be sole or decisive evidence with regards to charges 5a, 5b, 5c, 5d and 10. She also submitted that part of Person A's

evidence may not be considered sole or decisive evidence with regards to charges 5e, 7, 8 and 9.

Ms Stevenson submitted that Person A's evidence is relevant to the charges and that it is a matter for the panel to determine to whether it would fair to admit the evidence.

You submitted that Person A was the one person that you could have questioned on an equal footing, as unlike some of the other witnesses, you had worked together and did not feel inferior to her. You also submitted that, in relation to the alleged incidents, there had been actions taken that were not mentioned by Person A, and further that Person A had only worked part of a shift with you.

Therefore, you submitted that it would be unfair for the panel to accept this application.

The panel accepted the legal assessor's advice, and noted that hearsay evidence may be admitted in reliance on Rule 31 provided it is relevant to the charges and fair to both parties. The legal assessor referred to the cases of *R (Bonhoeffer) v GMC* [2011] EWHC 1585, *Thorneycroft V Nursing and Midwifery Council* [2014] EWHC 1565 admin, *El Karout v NMC* [2019] EWHC 28 (Admin), and *The Nursing and Midwifery Council v Ogbonna* [2010] EWCA Civ 1216.

The panel considered the submissions of Ms Stevenson, your submissions, Person A's witness statement, Person A's written statement to the Police and the evidence as a whole. Having done so it determined that Person A's evidence was relevant to the charges and the sole and decisive evidence with regards to charges 5a, 5b, 5c, 5d and 10.

The panel noted that Person A provided a witness statement to the Police which is consistent with her NMC witness statement. However, the panel noted from your submissions, that you would wish to challenge Person A's evidence under cross examination. You stated that the statement provided does not mention actions taken at the time to address the concerns raised, and further that as Person A worked only part of a

shift with you, she was not in a position to state that appropriate action was not taken as alleged.

In considering Person A's NMC witness statement and statement to the Police, the panel took into account, that when other witnesses supplied similar evidence, you had the opportunity to explore the answers that they gave by way of cross examination, and the panel availed of the opportunity to ask questions. If Person A's evidence is admitted as hearsay evidence, these opportunities will be missed.

The panel took into account that all reasonable efforts had been made by the NMC to secure Person A's attendance and also accepted that the reasons for her absence are genuine.

The panel took into account that the charges in this case date back to 2016, and that although there is no adjournment application, it has power to invite adjournment submissions. However, the panel considered that there is no certainty that an adjournment would secure Person A's attendance in the future. Furthermore, the panel determined that an adjournment would cause further delay in disposing of these charges and would be unfair to you.

The panel was also of the view that it may wish to question Person A's evidence consistent with the questions it asked of other witnesses.

The panel also took into account the seriousness of the relevant charges, and that if Person A's statement is admitted you would be disadvantaged in your ability to answer the charges beyond a bare denial.

The panel therefore refused the hearsay application.

The panel moved to consider the written statement dated 25 January 2022 of the Senior Human Resources (HR) Advisor for Larchwood Care Homes (North) Limited which

exhibited your Job Description as Home Manager of the Home. The panel considered the document referred to and took into account that you accepted it was your Job Description.

In these circumstances, the panel considered it appropriate to admit the Senior HR Advisor's written statement into evidence.

Decision and reasons on application for the NMC to offer no evidence

The panel heard an application made by Ms Stevenson to offer no evidence of charges 5a, 5b, 5c, 5d, and 10 because the panel rejected the NMC hearsay application.

The panel accepted this application to offer no evidence in relation to charges 5a, 5b, 5c, 5d, and 10. The panel noted that as Regulator, the NMC have a responsibility to investigate regulatory concerns. However, it determined that reasonable efforts had been made by the NMC to investigate the concerns raised in charges 5a, 5b, 5c, 5d, and 10 and that in the absence of Person A, there was nothing more the NMC could be reasonably expected to do.

The panel allowed the application to offer no evidence in relation to charges 5a, 5b, 5c, 5d, and 10.

Decision and reasons on application of no case to answer

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

- Witness 1: District Nurse Student covering Sowerby House at the time of the incident

- Witness 2: Inspection Manager for the [PRIVATE] in the Commission at the time of the incident
- Witness 3: Registered Manager at Sowerby House from November 2016
- Witness 4: Services Manager at North Yorkshire County Council at the time of the incident
- Witness 5: General Practitioner at Topcliffe Surgery

At the end of the NMC case, the legal assessor advised the panel of its discretionary power under Rule 24(7) of the Rules to invite no case to answer submissions from the parties.

The panel considered the disputed charges in turn, all the oral and written evidence relied upon by the NMC and having done so invited submissions as to whether there is a case for you to answer in relation to charges 1d, 1f, 2e, 5e, 7, 9, and 11b.

In response, Ms Stevenson provided detailed written submissions to assist you and the panel bearing in mind that you are unrepresented and written submissions may allow you to better understand the issues arising and the evidence relied upon by the NMC.

The panel accepted the advice given by the legal assessor who referred to the *Galbraith* test.

Ms Stevenson submitted in relation to charge 1d, in light of Witness 2 and Witness 4's oral evidence, that whilst the NMC submit there is sufficient evidence provided to find the facts proved, the NMC concede that this charge would not amount to misconduct.

Ms Stevenson submitted that there is a case to answer in relation to charges 1f, 2e, 9, and 11b. In relation to charges 5e and 7, she submitted that it was a matter for the panel. She took the panel through the charges individually and highlighted the evidence she relied upon in support of there being a case for you to answer. She submitted that the evidence provided is neither inherently weak, vague, or tenuous within the meaning of *Galbraith*.

You submitted that you understand Ms Stevenson's submissions but that you are at a loss to understand why there is a case to answer relative to charge 5e in particular.

The panel took account of the submissions made and accepted the advice of the legal assessor. The legal assessor also provided the panel and the parties with a written copy of her legal advice to assist your participation in circumstances where you are unrepresented.

In reaching its decision, the panel has made an initial assessment of all the evidence provided relative to the individual charges. The panel solely considered whether any evidence has been provided, and if so whether that evidence is of a sufficient quality within the meaning of the *Galbraith* test as to create a possibility of facts being properly found proved. It bore in mind that this is not a fact-finding exercise, or an exercise in determining credibility.

The panel found no case for you to answer in response to charges 1d, 5e and 7.

In relation to charge 1d, the panel determined that it has evidence from Witness 2 and Witness 4 to the effect that there is no requirement to apply to NYCC in respect of a deprivation of liberty safeguard, namely a sensor mat. Therefore, the panel was of the view that there was no written policy or guidance before it to understand what the minimal requirements were of you. It determined that there is no evidence to support a finding that whilst you were employed as the Registered Manager of the Home, the fact that there was no record in Resident A's care plan of an application being made to NYCC in respect of a

deprivation of liberty safeguard, namely a sensor mat, cannot be attributed to a failure on your part. The panel noted the concessions made by Ms Stevenson in this regard and determined that there is no case to answer relative to charge 1d.

In relation to charge 5e, the panel noted that the only direct evidence in support of this charge has been provided by Person A. The panel noted that Witness 4 gives evidence in support of this charge, but that evidence is second hand in that it provides information given to her by Person A, and third hand in that it provides information given to Person A by you. The panel having considered the nature of evidence overall, is satisfied that it is tenuous and inherently weak within the meaning of *Galbraith*. The panel therefore determined that you have no case to answer relative to charge 5e.

In relation to charge 7, the panel assessed the quality of evidence provided by the NMC. It considered the evidence from Witness 3 in relation to the use of a dependency tool to indicate required staffing levels. However, it took into account that it was not provided with this, or any other evidence of staffing levels or deficits in staffing during the relevant period. The panel therefore determined that the evidence relied upon by the NMC is vague and tenuous within the meaning of *Galbraith*. The panel determined that you have no case to answer relative to charge 7.

The panel was of the view that you have a case to answer in relation to charges 1f, 2e, 9, and 11b.

In relation to charge 1f, the panel was of the view that it has been provided with evidence in support of this charge. It took into account Witness 2's witness statement dated 29 June 2023 and Witness 4's witness statement dated 17 May 2018, as well as their oral evidence. Both witnesses refer to concerns being raised by separate members of Person A's family relative to medication patches. The panel also took into account General Practitioner (GP) records confirming that Resident A was prescribed patches albeit post-dating the concerns. Taking the evidence as a whole, the panel considered there is evidence in support of this

charge and that it is not inherently weak, vague or tenuous within the meaning of *Galbraith*. The panel therefore determined that there is a case to answer relative to charge 1f.
In relation to charge 2e, the panel considered the oral and written evidence of Witness 2, to include evidence given by Witness 2 to [PRIVATE]. It noted that the evidence is clear as to the requirement for and absence of a formal assessment of Resident A's mental capacity. The panel therefore determined that you have a case to answer relative to this charge.

In relation to charge 9, the panel considered the evidence of Witness 3 and their explanation of the documents relied upon to support their conclusions relative to training for new starters. The panel noted the different aspects of training required for new starters to include induction shadowing and probationary periods. Taking all these factors into consideration, the panel determined that you have a case to answer relative to charge 9.

In relation to charge 11b, the panel was of the view that it had sufficient evidence to find that there is a case to answer. The panel considered the evidence relied upon by the NMC in support of this charge. It took into account that the charge relates to an unknown Resident, identified as Resident XXX. However, it also took into account that the circumstances of Resident XXX's admission to the home are described which may facilitate your recollection of the Resident and your understanding of the charge. The panel also had regard to clear evidence of an absence of a Care Contract for Resident XXX and in these circumstances determined that there is a case for you to answer relative to this charge.

Decision and reasons on facts

At the outset of the hearing, after the charges had been read, you informed the panel that you made full admissions to charges 2c and 2d.

The panel therefore finds charges 2c and 2d proved in their entirety, by way of your admissions.

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

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

The panel heard oral evidence from the witnesses called on behalf of the NMC, that are listed previously in this determination.

The panel also heard evidence from you under affirmation.

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

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

Charge 1a)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident A, you did not ensure his dietary requirements and/or food supplementation and/or fluid intake was being adequately identified and managed".

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's and Witness 4's evidence, namely, Witness 2's witness statement dated 13 July 2018, her supplementary witness statement dated 29 June 2023, and her live oral evidence; and Witness 4's witness statement dated 17 May 2018.

Witness 2 directed the panel to the Daily Food and Fluid Record Chart dated 30 March 2016 and 31 March 2016. The panel noted that it does not have all of the information that it could have before it, including the absence of a care plan. Further, it noted that Witness 2 said in her oral evidence that some of these entries are not filled in too badly but that they could have been recorded better.

The panel noted that the Hourly Fluid Chart dated 30 March 2016 shows that although Resident A was given fluids from 09:00 to 17:00, there are 14 hours unaccounted for whereby there is nothing recorded on the chart. The panel noted that the same chart dated 31 March 2016 indicated that Resident A was only having fluids recorded from 09:00 to 15:00. Although you said you were present for handovers every day when you were at work, even if you did checks on 31 March 2016, the panel was of the view that there is no evidence of any management input.

The panel noted that Witness 2 stated, in her supplementary witness statement dated 29 June 2023:

> *'In my initial NMC statement, I stated that there were gaps in Resident A's daily food and fluid record charts. In these records, the expected input is at the top of the documents and the daily total input is at the bottom of the documents. The total input is important for a resident who is unwell and should be recorded. A copy of one of Resident A's daily food and fluid record charts is exhibited as Exhibit KR/4.9'.*

The panel also took into account Witness 4's witness statement dated 17 May 2018, whereby she stated:

'The first referral regarding Resident A came from his wife. She was concerned about the case Resident A was receiving. Resident A had lost two stone over the last two years, a lot of which occurred at Sowerby House. Resident A's wife did not feel he was receiving enough fluids…' [sic].

During your oral evidence, you told the panel that the accountability for the overall care of residents fell to you, and as per point 9 of your job description *'Effectively monitor the care planning and ongoing evaluation of care',* the panel was satisfied that you held overall responsibility in your role as a registered manager.

The panel was of the view that it was not provided with all documentation in relation to Resident A. The panel noted that you said in your oral evidence that Resident A's family would have given Resident A fluids and you accepted that this was not recorded. It noted that you also accept that you should have checked and monitored Resident A. The panel also noted that the input to the Speech and Language Therapy (SALT) team for Resident A and the charts reflected that fluids had been declined on occasions.

The panel was therefore of the view that you had a duty to ensure that Resident A's dietary requirements and/or food supplementation and/or fluid intake was being adequately identified and managed. The panel took into account the concerns raised by Resident A's family, the charts provided to the panel indicating gaps in recording and your acceptance as Registered Manager of ultimate responsibility for Resident A's overall care.

The panel concluded, on the balance of probabilities, that it was more likely than not that you did not ensure that Resident A's dietary requirements and/or food supplementation and/or fluid intake was being adequately identified and managed because the documentary evidence shows gaps in Resident A's food and fluid charts and that Witness 2 and Witness 4 provided compelling evidence in their witness statements and oral evidence consistent with the contemporaneous safeguarding referrals.

Therefore, the panel found charge 1a proved.

Charge 1b)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident A, you did not ensure that an adequate standard of record keeping was being maintained in respect of his records".

This charge is found proved.

In reaching this decision, the panel took into account Resident A's care records, including the Daily Food and Fluid Record Charts, the Hourly Fluid Chart dated 30 March 2016, and the Repositioning and Continence Care Chart dated 29 March 2016. The panel was of the view that there were significant unexplained gaps.

In your oral evidence, the panel noted that you accepted that there were shortcomings in record keeping within the Home. The panel also noted that you said that you attended morning handovers on each day that you worked. You also said that you did daily management walk rounds and spot-checks, and you told the panel that you would review charts and paperwork. Having carefully considered your evidence against the significant gaps in the records, the panel cannot be satisfied that you adequately managed to ensure that an adequate standard of record keeping was being maintained in respect of Resident A's records.

The panel concluded, on the balance of probabilities, that it was more likely than not that you did not ensure that an adequate standard of record keeping was being maintained in respect of Resident A's records.

Therefore, the panel found charge 1b proved.

Charge 1c)

“That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House (“the Home”) between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident A, you did not ensure that adequate documentation was maintained in respect of consent and/or mental capacity assessments that had taken place”.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2’s oral evidence and all the documentary and oral evidence provided including your evidence.

The panel noted the evidence of Witness 2 to the effect that maintenance of the documentation recording consent and/or mental capacity assessments was not a mandatory requirement. The panel accepted this to be the case on reliance on Witness 2’s knowledge and experience and noted that this is consistent with your own evidence.

Further, the panel noted that it was not given any evidence to suggest that documentation was required in respect of consent. It also noted from Witness 2’s oral evidence that it was merely desirable as opposed to being a mandatory requirement.

In light of the above, the panel was of the view that it cannot be satisfied that on the balance of probabilities you had a responsibility to ensure that adequate documentation was maintained in respect of consent and/or mental capacity assessments in respect of Resident A.

Therefore, the panel found charge 1c not proved.

Charge 1e)

“That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House (“the Home”) between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident A, you did not ensure his care plan contained a proper assessment as to his ability to consent to care and treatment”.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 2 and your evidence. The panel was not provided with a complete Care Plan and there is no evidence to suggest that a proper assessment as to Resident A’s ability to consent to care and treatment may not be filed or recorded elsewhere. The panel was of the view that in absence of all the care plan records, the panel cannot be satisfied that a proper assessment as to Resident A’s ability to consent was not contained elsewhere.

The panel noted that Witness 2 describes this as best practice but not mandatory. This is consistent with your own evidence. The panel also did not have sight of a relevant policy or guidance as to the requirement for an assessment of residents’ ability to consent to care and treatment.

In your oral evidence, you described the archiving filing system as chaotic. Further, the panel was aware that there was a period of months between you leaving the Home and the documents being removed/seized.

The panel was of the view that it cannot be satisfied that on the balance of probabilities you did not ensure Resident A’s care plan contained a proper assessment as to his ability to consent to care and treatment.

Therefore, the panel found charge 1e not proved.

Charge 1f)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident A, you did not ensure that correct medication patches were being applied properly by staff and/or changes were being made in line with prescribing instructions".

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence provided in relation to this charge including Resident A's GP record, the safeguarding concerns raised by Resident A's family, and your oral evidence.

The panel noted that there was reference to medication patches in the GP's medical records for Resident A but has not been provided with the prescription or the Medication Administration Record (MAR) charts and a body map. The panel noted your detailed evidence in relation to the body map which would have been in place to indicate the sites on which the patches were placed. The panel also noted your evidence regarding the packaging in which the patches would come, and the need for the patches to be placed on different sites to ensure efficacy of treatment. The NMC did not provide the panel with the documentation you referred to in your evidence.

The panel balanced your clear evidence relative to documentation and the process of administration, against evidence from Witness 2 that only a sample of documentation was taken from the Home. Having done so, the panel determined that it is probable there was documentation to support your case, but that documentation was not included in the sample taken by the CQC inspectors and so was not provided to the panel.

In all these circumstances, the panel is not satisfied on the balance of probabilities that you did not ensure that medication patches were being applied properly be staff and/or changes were being made in line with prescribing instructions.

Therefore, the panel found charge 1f not proved.

Charge 1g)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident A, you did not ensure that staff adhered to safe medication administration, in that they did not observe that medication had been safely ingested".

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident A's Safeguarding Report dated 29 March 2016, Witness 4's witness statement and oral evidence, the evidence of Witness 5, and your evidence.

The panel took into account the evidence of Witness 4 where she stated:

> *'The white gunge turned out to be medication. He was unable to swallow'.*

The panel took into account the Safeguarding Report dated 29 March 2016, which refers to Resident A's wife, which stated:

> *'She looked into her mouth and there was "white gunge" at the back of his throat.* [PRIVATE].*'*

Resident A's wife also reports that a staff member:

> *'…advised that the "white gunge" was his medication from earlier and he and not swallowed it…'.*

Resident A's wife further reports that:

> '*Resident A had been seen by a doctor who advised that Resident A had* [PRIVATE]*'.*

The panel heard conflicting evidence relative to this charge. Resident A's wife reported seeing gunge at the back of Resident A's throat which she attributed to a recurrence of [PRIVATE]. The panel also considered information that a staff member indicated following their examination of Resident A that the white gunge was in fact medication. The panel also considered information that Resident A had subsequently been visited by a doctor [PRIVATE]. The NMC has not provided the panel with any clinical records in support of this charge.

The panel carefully considered all the information before it and took into account the Safeguarding Report. However, it concluded that there is no direct evidence to support this charge. Neither is there any contemporaneous clinical record. In these circumstances, the panel cannot be satisfied as to whether the white gunge reported by Resident A's wife was medication that was not safely ingested, a symptom of [PRIVATE].

The panel was of the view that, after very careful consideration, it cannot be not satisfied that on the balance of probabilities you did not ensure that staff adhered to safe medication administration, in that they did not observe that medication had been safely ingested.

Therefore, the panel found charge 1g not proved.

Charge 1h)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident A, you did not ensure that staff promptly undertook testing for signs of a [PRIVATE] which resulted in a delay in Patient A receiving antibiotics".

This charge is found NOT proved.

In reaching its decision, the panel took into consideration the safeguarding alert dated 22 April 2016, and the written and oral evidence of Witness 2 and Witness 4.

Within the safeguard alert, the panel noted the below information relayed to the referrer by Resident A's son:

> *"…The family are concerned about a delay in "obtaining a urine sample* [PRIVATE]*"*

The panel is aware that the above limited information is the only direct and contemporaneous record before it in respects of this charge, and that it is not clear from the referral the day on which the alleged delay to obtain a urine sample may have taken place.

In response to this charge, the panel heard your oral evidence that you cannot say where you were on the day of the alleged incident because you cannot recall it, but that in any

event, the staff and nurses at the home had a responsibility to carry out their known duties.

The panel also carefully considered the evidence of Witness 2 and Witness 4, noting that neither provide direct evidence to support this charge but that in their professional opinion, as the Registered Manager of the home, you had an ultimate responsibility for its complete oversight, and that you should have had a clear picture of the level of care provided within the home.

However, in light of all of the above, and in the absence of any clinical or care documentation evidencing symptoms of the urine infection or the steps that were taken, or otherwise, by the home to obtain a urine sample from Resident A during the period set out in the charge, the panel determined that it cannot be satisfied on the balance of probabilities that you failed to ensure that staff promptly undertook testing for signs of [PRIVATE] which resulted in a delay in resident A receiving antibiotics.

Therefore, the panel found charge 1h not proved.

In relation to charge 1, the panel found charges 1a and 1b proved, and charges 1c, 1e, 1f, 1g, and 1h not proved.

Charge 2a)

“That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House (“the Home”) between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident B, you did not ensure that an adequate standard of record keeping was being maintained in respect of his records”.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's oral and written evidence including her exhibits regarding Resident B's care records to include the Continence Care Records, the Daily Nutritional Charts, and the 30-minute Observation Record.

The panel noted that Witness 2 stated the following paragraphs in her witness statement to the Coroner dated 16 February 2017:

> *'Concerns were apparent in relation to the record keeping in relation to Resident B's care. A pre-admission assessment document dated 24 June 2016, completed by the Deputy Manager was not fully completed; provided only minimal information and did not give an accurate picture of Resident B's care needs. For example tick boxes were not completed. Also, under the heading 'Mobility', it stated "can stand to transfer" but a needs assessment completed by North Yorkshire County Council, stated that he had reduced mobility. The pre-assessment also failed to detail any suitable equipment for Resident B to use such as a walking stick or Zimmer walking frame.'*

The panel noted that it was not provided with all the documents that Witness 2 refers to by way of corroboration.

The panel had sight of a number of Resident B's Continence Care Charts demonstrating significant gaps suggesting a lack of management oversight and whilst it noted there were entries, there were also long periods of time with no entries whatsoever. It also saw some good evidence of record-keeping on some of the Daily Nutrition Charts, but there still remains some gaps to include no entries over the evening and night period. The panel took into account that fewer entries on the Daily Nutrition Chart (which detailed food and fluid taken) during the evening and night period is to be expected. However, the panel took into account that for a resident that was so frail and receiving end of life care, it would

have expected to see more entries on the charts to indicate the interventions from the care team, for whom you were ultimately responsible.

In your oral evidence, the panel noted that you accepted that there were shortcomings in record keeping within the Home. The panel also noted that you said that you attended morning handovers on each day that you worked. You also said that you did daily management walk rounds and spot-checks, and you told the panel that you would review charts and paperwork.

Notwithstanding that the panel saw good evidence of record-keeping on Resident B's half-hour Observation Chart dated 11 July 2016, the panel concluded, on the basis of the documents provided to it by the NMC, to include incomplete Continence Care Records, that on the balance of probabilities, that it was more likely than not that you did not ensure that an adequate standard of record keeping was being maintained in respect of Resident B's records.

Therefore, the panel found charge 2a proved.

Charge 2b)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident B, you did not ensure that his dietary requirements and/or fluid intake was being adequately identified and managed".

This charge is found proved.

In reaching this decision, the panel took into account Resident B's daily nutritional records, the oral and written evidence of Witness 2 and Witness 5, and your oral evidence.

The panel noted that Witness 2 gave oral evidence regarding the lack of Resident B's documentation to enable CQC to make an assessment of his dietary requirements and fluid intake. This was consistent with comments in her witness statement dated 13 July 2018:

> *'…daily nutrition charts were not complete. No charts recorded that a purée diet had been offered, as entries made indicated that fluid and food intake had been poor'.*

> *'…An undated and unsigned nutritional assessment placed Resident B in the high risk category, but no subsequent risk management plan was it in place in respect of his nutrition and hydration'.*

The panel also noted the evidence from Witness 5 about Resident B having an inappropriate diet as witnessed by her:

> *'It was lunchtime when I saw Resident B and I noticed that his eyesight was very poor and he was sitting a distance from table where he could not reach his meal very well. He was having fish and chips and ended up using his hands to try and eat. Resident B only had two teeth and this was a completely inappropriate diet for him'.*

The panel assessed the identification and management of Resident B's dietary requirements and/or his fluid intake by taking account of the Daily Nutritional Charts provided by the NMC. The panel noted that such charts are in place for the purposes of enabling those caring for Resident B to identify and fulfil his dietary requirements on a daily basis. The panel noted that, Witness 2, in her statement to [PRIVATE] dated 16 February 2017, stated:

'…No information within the care plans of the input to his care plan by the SALT team. This heightened the risk of staff not knowing how much thickener to use in his drinks or the SALT advice to provide a pureed diet.'

The panel noted that there were some good entries on the charts recording his food and fluid intake, for example the record dated 3 July 2016. However, the panel is concerned about the lack of vital information more generally in the charts provided and considers that this demonstrates poor identification and management of Resident B's dietary requirements and fluid intake.

In your oral evidence you said that not all residents who are deemed 'end of life' are on a purée diet but that looking at Resident B's Daily Nutritional chart dated 3 July 2016 he was given roast beef, and this would have been puréed. You agreed that there is no evidence on the chart to show that this was the case and that this is bad practice.

Taking into account all of the above, and after considering your evidence, the panel concluded, on the balance of probabilities, that it was more likely than not that you did not ensure that Resident B's dietary requirements and/or fluid intake was being adequately identified and managed.

Therefore, the panel found charge 2b proved.

Charge 2e)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident B, you did not ensure that there was a formal assessment of his mental capacity contained in his care records."

This charge is found NOT proved.

In reaching this decision, the panel took into account all the documentary and oral evidence provided to include your evidence and Witness 2's evidence.

The panel noted the evidence of Witness 2 to the effect that maintenance of mental capacity assessment was best practice but was not a mandatory requirement.

The panel took into account that it was not provided with any evidence that the Mental Capacity Act was engaged relative to Resident B and it is not for the panel to speculate in this regard.

The panel was of the view that, for this reason, and taking into account the evidence of Witness 2, the panel cannot be satisfied that on the balance of probabilities you had a responsibility to ensure that there was a formal assessment of Resident B's mental capacity contained in his care records.

Therefore, the panel found charge 2e not proved.

In relation to charge 2, the panel found charges 2a and 2b proved, and charge 2e not proved.

Charge 3a)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident C, you did not ensure that an adequate standard of record keeping was being maintained in respect of his records".

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident C's care records, and your oral evidence.

The panel noted that during the period of 29 June 2015 and 15 July 2016 as per the charge, there is sufficient evidence of good and adequate record keeping. For example, the panel noted that Resident C's wound care records were adequately maintained in 2016 including the dates listed in the charge.

Further, the panel noted that within Resident C's wound care records, via the entries on 11 February 2016 and 17 January 2016, there is reference to Resident C being *'redressed as care plan'*. However, the NMC did not provide the panel with the latter document.

Taking into account the above, particularly evidence of good record-keeping in the documentation provided to the panel by the NMC in respect of Resident C, the panel cannot be satisfied that on the balance of probabilities you did not ensure that an adequate standard of record keeping was being maintained in respect of Resident C's records.

Therefore, the panel found charge 3a not proved.

Charge 3b)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, in respect of Resident C, you did not ensure that records adequately recorded what action had been taken between February and March 2016 to treat his wound".

This charge is found NOT proved.

In reaching this decision, the panel took into account Resident C's wound care records, and your oral evidence. It adopted very similar views as those in charge 3a. The panel had sight of 10 entries in the wound care records of Resident C over the period of February and March 2016. These included reference to the involvement of the Tissue Viability Nurse.

In your evidence, you said that there were photographs taken of the wound and that there was a wound care plan in place at the relevant time. You also said that a new wound care plan would be written each time the wound care needs change.

In the wound care records, on 11 February 2016 and 31 March 2016, the panel noted entries that said, 'redressed as plan'. This indicated that there was a care plan in place at the relevant time, but the NMC did not provide photographs or this care plan to the panel.

However, the care plan is referenced in the wound care records and the panel therefore conclude on the balance of probabilities that there was a care plan in place and that it referred to the action to be taken in respect of Resident C's wound.

The panel was of the view that it has good records of Resident C's wound care between February and March 2016 and that the actions taken were adequately recorded.

Given the above, the panel cannot be satisfied that on the balance of probabilities you did not ensure that records adequately recorded what action had been taken between February and March 2016 to treat Resident C's wound.

Therefore, the panel found charge 3b not proved.

In relation to charge 3, the panel found charges 3a and 3b not proved.

Charge 4a)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, on or around 14 July 2016, you failed to ensure that Resident B was being adequately cared for by staff in that he was lying in faeces and urine".

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement dated 22 March 2018, Witness 1's oral evidence, and your oral evidence.

The panel is satisfied that in accordance with your job description you had responsibility to ensure that Resident B was being adequately cared for by staff.

During your oral evidence, the panel noted your distress that such an event would have taken place whilst you were the registered manager. However, the panel carefully considered the evidence of Witness 1 and found her recollection as to what she found when visiting Resident B to be very clear. The panel took into account that Witness 1 reported her findings to the safeguarding team and determined that this contemporaneous action corroborates her evidence relative to this charge.
The panel was of the view that that on the balance of probabilities, you failed to ensure that Resident B was being adequately cared for by staff in that he was lying in faeces and urine.

The panel therefore found charge 4a proved.

Charge 4b)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, on or around 14 July 2016, you failed to ensure that Resident B was being adequately cared for by staff in that his documentation had not been completed in over four hours".

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement dated 22 March 2018, Witness 1's police statement dated December 2016, the notes of evidence at the inquest dated 5 April 2017 which includes Witness 1's comments, Witness 1's oral evidence and your oral evidence.

The panel noted that Witness 1 said to [PRIVATE]:

> *'I said to them, "Have you forgotten to fill his chart in?" because sometimes that does happen, and they said, "No, we've been busy." So I said, "What have you been busy doing?" and they said, "Toileting," and I did say, "For four hours?" and then they left the room.'*

The panel also noted that Witness 1 stated in her witness statement dated 22 March 2018 that:

> *'After I had finished speaking with Joanne, I went upstairs to support my colleague with a patient, Resident B. I went upstairs to see Resident B. His wife was there with him at the time. Resident B looked dry and thirsty. His mouth was dry and his*

lips were cracked…I looked at Resident B's positioning chart, as part of my role was to check that this had been completed properly. I found that Resident B's positioning chart had not been completed for 4 or 4.5 hours. There was nothing written in Resident B's records since 12:00. I think we saw him around 16:30. I rang the buzzer and one of the carers came. I asked whether they had forgotten to fill the chart in, as sometimes this does happen. However, they said they had been busy and had not been able to see Resident B. the charts should have been completed either one or two hourly. The carers should have also have been checking on resident B this frequently.'

Further, the panel noted that when looking at Resident B's Continence Care records, there were gaps of over four hours shown overnight, for example, on 13 July 2016 and also on 15 July 2016.

Although the panel did not have the repositioning chart before it, it found Witness 1's evidence to be credible, consistent and in some parts more contemporaneous.

The panel was of the view that that on the balance of probabilities, you failed to ensure that Resident B was being adequately cared for by staff in that his documentation had not been completed in over four hours.

The panel therefore found charge 4b proved.

Charge 4c)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that, on or around 14 July 2016, you failed to ensure that Resident B was being adequately cared for by staff in that when notified by Person B

of his presenting condition, you did not ensure that he was promptly seen and/or assessed".

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement dated 22 March 2018, the notes of evidence at the inquest dated 5 April 2017 which includes Witness 1's comments, Witness 1's oral evidence and your oral evidence.

The panel noted that Witness 1 was not in a position to comment on what you did following her report to you as she then left the Home soon afterwards. You told the panel that you recall the event and said that you had taken action after Witness 1 had left.

The panel considered the evidence of Witness 1 and your evidence. It noted that Witness 1 was unable to speak to the actions taken by you when notified of Resident B's presenting condition because Witness 1 left the home shortly afterwards. The panel noted your evidence of the actions taken by you to ensure that Resident B was promptly seen and/or assessed and therefore cannot be satisfied on the balance of probabilities that you failed to ensure that Resident B was being adequately cared for by staff in that when notified by Person B of his presenting condition, you did not ensure that he was promptly seen and/or assessed.

Therefore, the panel found charge 4c not proved.

In relation to charge 4, the panel found charges 4a and 4b proved, and charge 4c not proved.

Charge 6)

“That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House (“the Home”) between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that you did not carry out regular audits of records to ensure they were being completed by staff to an adequate standard”.

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence provided relative to this charge.

The panel is satisfied that in accordance with your job description you had responsibility to carry out regular audits of records to ensure they were being completed by staff to an adequate standard.

The panel noted the evidence of Witness 3 but took into account that although he referred to some records in the context of this charge to include dependency tools and the Cold Harbour system, those records were not provided to the panel. The panel also took into account that Witness 3 came into post four months after you left your employment at the Home.

The panel was not provided with the documentation that Witness 3 relied upon to support his conclusions regarding your auditing. He did concede that only some records were made available to him.

The panel considered your evidence that you had carried out regular audits, and that your systems were regularly audited by your Regional Manager. You did concede that with the benefit of hindsight your records could have been better, but you were very clear as to the auditing undertaken by you.

Given the above, the panel cannot be satisfied that on the balance of probabilities you did not carry out regular audits of records to ensure they were completed by staff to an adequate standard.

Therefore, the panel found charge 6 not proved.

Charge 8)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that you did not ensure that staff were up to date with their mandatory training and/or that staff supervisions were being carried out".

This charge is found proved.

In reaching this decision, the panel took into account all the evidence provided relative to this charge.

The panel noted that it had not been provided with evidence before it of what training staff had carried out. However, the panel noted that it has evidence that training was an issue in the Home and there is also evidence of discussion taking place about training. The panel noted this to be within Witness 4's meeting minutes dated 29 February 2016 as it states:

> *'The Quality Assurance and Procurement Officer stated that she is concerned that new staff are not undertaking training soon after commencement of employment. The Home Manager stated that she is awaiting dates for all new starters to undertaken their training and then all staff who are not up to date with training will do theirs. The Home Manager confirmed that new starters should undertake*

Induction, Fire Safety and Moving and Handling on commencement of employment. The Home Manager also confirmed that face to face training had been undertaken regarding SOVA and POVA and that Food Hygiene has been undertaken also. The Quality Assurance and Procurement Officer asked the Home Manager to revisit the training with staff.'

The panel noted that it was the responsibility of the registered provider of the Home to procure staff training. It also noted your evidence about the difficulties you encountered in sourcing staff training, and the further difficulty arising by your concern that not all staff had access to a laptop or the right technology to participate in e-learning at home.

In your oral evidence, you told the panel that there was not a trainer available from the new management company when it changed hands.

The panel also noted that Witness 3 agreed that you had raised concerns with the Registered Provider in regard to training. The panel noted the issues you encountered in trying to secure training for staff and accept that these issues were outside your control.

The panel considered charge 8 in so far it related to staff supervisions being carried out. The panel was not provided with any evidence to support this limb of the charge. The only evidence before the panel was from Witness 3 who, in response to questioning about staff supervisions indicated:

'I do not have that information'.

The panel therefore find this limb of the charge not proved.

In light of all of the above, the panel was of the view that in accordance with your job description as registered manager, you were ultimately responsible for ensuring that staff are up to date with their mandatory training. The panel accepted the difficulties you encountered relative to training and the effort made by you to secure training. Nonetheless, the panel accepted that staff were not up to date in their mandatory training and ultimately this responsibility falls to you.

The panel is satisfied that you did not ensure that staff were up to date with their mandatory training, so therefore finds this charge proved.

Charge 9)

“That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House (“the Home”) between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that you did not ensure that new starters undertook appropriate training soon after commencement of their employment”.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence provided relative to this charge and noted that the evidence considered in charge 8 applies equally to new starters. In addition, the panel noted that new starters are required to undertake shadowing, induction and complete a probationary period.
When considering this charge, the panel took a similar view as set out in charge 8 above. For the same reasons given in relation to that charge, the panel found this charge proved on the balance of probabilities.

Therefore, the panel found charge 9 proved.

Charge 11a)

"That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House ("the Home") between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that you inappropriately admitted the following residents to the Home when an assessment of suitability had not been carried out and/or a care contract was not in place: Resident E".

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence provided to include your oral evidence, your account of the referral received for Resident E's admission to the Home and, of your visit to him for the purposes of assessing his suitability.

The panel is satisfied that in accordance with your job description you had responsibility to ensure that all residents were appropriately admitted to the Home. You were the Manager of the Home at the time Resident E was admitted albeit you were not the Registered Manager.

The panel noted that you gave evidence of visiting Resident E for assessment purposes with a named colleague, and at the time of the assessment Resident E did not present with any aggressive behaviours. Further your evidence was that previous challenging behaviours on the part of Resident E were attributed to [PRIVATE].

The panel was of the view that at the point of admission to the Home, on the balance of probabilities, Resident E had been assessed for suitability by you, and that you had formed a judgement based upon his presentation at the time and that his admission was

appropriate. The panel noted that, when asked by you, Witness 4 did not know whether the safeguarding team had asked to see the admission document for Resident E.

The panel took into account that provision of a Care Contract was the responsibility of the Council albeit you had responsibility to ensure it was in place prior to admission. The panel noted the purpose of the Care Contract and noted the funding implications flowing from a Care Contract. There was no supporting evidence before the panel to evidence that there was no Care Contract in place. The panel therefore decided that it was unlikely that Resident E would have been admitted to the Home without a Care Contract in place. The panel also took into account your oral evidence, that there was a Care Contract in place for Resident E.

The panel is not satisfied that you inappropriately admitted Resident E to the Home when an assessment of suitability had not been carried out and/or a care contract was not in place.

The panel therefore found charge 11a not proved.

Charge 11b)

“That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House (“the Home”) between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that you inappropriately admitted the following residents to the Home when an assessment of suitability had not been carried out and/or a care contract was not in place: Resident XXX”.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 4, the safeguarding referral and your evidence on the admissions process generally. The panel also took into account that you cannot identify Resident XXX and therefore cannot recall specific circumstances of their admission.

The panel is satisfied that in accordance with your job description you had responsibility to ensure that all residents were appropriately admitted to the Home. You were Registered Manager of the Home at the relevant time.

The panel noted that you gave very clear evidence of the procedures followed by you, when assessing the suitability of residents; the input required of various external parties, and the admission process itself. It also noted that you gave evidence of the steps taken to include the identification of available beds, the assessment of each resident, their needs and abilities, and discussions with the next of kin.

The panel took into account that provision of a Care Contract was the responsibility of the Council albeit you had responsibility to ensure it was in place prior to admission. The panel noted the purpose of the Care Contract and noted the funding implications flowing from a Care Contract.

The panel took into account that unlike Resident E, you cannot identify Resident XXX. The panel took into consideration the evidence of Witness 4 who was also unable to identify Resident XXX and noted that the only evidence supporting this particular charge was the anonymised safeguarding report dated 17 February 2016 which contains very limited information and does not assist in the identification of Resident XXX.
The panel therefore found charge 11b not proved.

Charge 12)

“That you, a Registered Nurse, whilst employed as the Home Manager / Registered Manager of Sowerby House (“the Home”) between 29 June 2015 and 15 July 2016 failed to manage the Home effectively in that you did not fully engage with safeguarding procedures when raised by North Yorkshire County Council (NYCC”)”.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4’s oral and written evidence and all the relevant evidence before it in relation to this charge, including your oral evidence.

The panel noted that there were a series of safeguarding meetings in relation to the concerns raised at the Home which you were invited to as the Home Manager. The panel is aware that whilst you attended and engaged in some of these meetings, you were not able to attend all of them. You informed the panel that, on one particular occasion, you were unwell, and therefore not in a position to attend. You also told the panel that on another occasion you mistakenly went to the wrong meeting location.

In light of the above, on the balance of probabilities, the panel is of the view that you did not fully engage with safeguarding procedures when raised by NYCC and therefore finds 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 your fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant’s suitability to remain on the register unrestricted.

The panel, in reaching its decision, 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

At the outset of misconduct and impairment, you gave evidence under affirmation.

You told the panel that you began your nursing career at the age of 18 and have spent ten years working night duties. You told the panel that you received a qualification in elderly care through the University of Sterling and also that teaching became part of your role for a long time through many jobs. You believe that training is very important.

You told the panel that, following a CQC visit, you won a 'Management of The Year Award' for your forward thinking, which included your proposals of collaborative notes and doctor sheets. This was designed to make things easier for CQC visits. You said that your records were previously very good. Prior to working at the Home, you said that you were used to using your own brain to try to solve paperwork problems. However, at the Home, you did not have the autonomy to do that.

In relation to record-keeping, you said that you found it very difficult to manage records by yourself. You told the panel that it was difficult for your deputy to support you as she was working on the floor which is often not the case in many care homes. You said that, ever since the charges were made against you, you stopped to think about your practice as it was a big shock and has impacted on your life/work life. You told the panel that you are not an obsessive person, but it has made you constantly question yourself, whilst being aware of you having a duty of candour.

Additionally, you said that you have to ensure that information is written down carefully and thoughtfully. You said that with openness and a duty of care, you try to ensure that you reflect patients' requirements/needs when writing care plans so that it is clear what needs to be done. As an example, you told the panel that you would write exactly what the patient has eaten, and not just that the patient has eaten as it is important to establish a record of patients' needs and wants. You accepted that your record-keeping could have been more detailed. You told the panel that time management was not your strongest point and that you struggled to do the required six supervisions a year for each member of staff, and you were the only person qualified to do that. You explained that you raised these concerns with your manager during monthly visits, but you felt there was a lack of support from the company.

Ms Stevenson then invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of **'**The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision. She referred to paragraphs 7, 8, 9, 10, 11 and 25 of the Code.

Ms Stevenson identified the specific, relevant standards where your actions amounted to misconduct. She referred to the cases of *Roylance v GMC* [2000] 1 AC 311, *Calhaem v GMC* [2007] EWHC 2006 (Admin), and *Nandi v GMC* [2004] EWHC 2317 (Admin).

Ms Stevenson submitted that you had a number of duties and responsibilities as Home Manager/Registered Manager. She submitted that you had a duty to ensure that the

Residents dietary requirements and/or food supplementation and/or fluid intake was being adequately identified and managed. You also had a duty to ensure there was an adequate standard of record keeping and written guidance for staff and to ensure that a risk management plan was put in place for Resident B who was a vulnerable resident due to being placed in the higher risk category.

Ms Stevenson submitted that some of the concerns in this case were repeated over a period of time, namely between 29 June 2015 and 15 July 2016. She submitted that the concerns are wide-ranging. She submitted that the evidence suggests that the CQC rating of the Home decreased during the time that you were the manager. Prior to you becoming the Registered Manager, the Home was inspected on 19 February 2015 and 08 April 2015. Ms Stevenson informed the panel that the Home had been given an overall rating of “good” at this time. She submitted that after you resigned as the Registered Manager, the Home was inspected on 13, 14 and 19 October 2016 and was given an overall rating of “inadequate” at this time.

Ms Stevenson further submitted that a number of vulnerable residents were placed at a real risk of harm over a sustained period of time. She submitted that there are also potential attitudinal concerns in relation to the lack of engagement with safeguarding. For example, during your evidence at the misconduct and impairment stage, you explained that due to negative remarks from safeguarding you had lost faith to work with them. Ms Stevenson submitted that concerns persisted despite safeguarding meetings and/or warnings about the same mistakes continued to be made and the quality of care needing to improve.

Ms Stevenson submitted that colleagues would expect that they could rely upon their manager to guide them, act as a role model, lead them to make sure people’s wellbeing are protected, and to improve experiences of the healthcare system. Equally, they would expect to work together as a team, communicate effectively and deliver safe and effective care as well as to be accountable for decisions to delegate tasks and duties to other people.
Therefore, Ms Stevenson submitted that your actions as found to be misconduct fall far short of what would be expected of a Registered Nurse. Ms Stevenson submitted that the public

would expect that the profession would be dependable and properly care for friends, relatives and members of the public. She submitted that they would expect nurses to uphold a professional reputation.

Submissions on impairment

The panel first heard from you, under affirmation.

You told the panel that it is important that patients are cared for with dignity. You said that the incident had an effect on you as it stopped you from applying for jobs. In response to Ms Stevenson's questions, you confirmed that you are working for an agency, namely Unity Plus. You said that you aim to undertake only three shifts a week, all of which are during the day. You have not undertaken any other roles whilst employed with your current agency. You said that quite often you are the only nurse in the building which makes you the nurse in charge by default. You intend to continue to work but plan on reducing the number of shifts as you approach retirement.

In relation to whether you are of the view that you pose a risk of repetition, you told the panel that your record-keeping is still checked regularly. You said that if you were to find yourself in a similar situation in the future, you would discuss what has happened and how you can prevent it from happening again, with somebody who was doing the care plans as well as with the team. You told the panel that you would prevent yourself from being in a similar situation in the future by ensuring that paperwork is complete and by speaking to the team regarding the best way in managing a situation as you have to be person-centred.

In response to the panel and in relation to how you think a fully informed member of the public would feel if they were aware of the allegations against you, you said that they may be shocked but would also remember that most nurses are kind, caring and professional. You said that this was a mistake you made in the past and that members of the public would not tarnish all nurses with the same brush. In relation to the impact your actions

have had on patients and colleagues, you said that the incident occurred seven years ago. You have spoken to people about the NMC and the charges against you. You said that, overwhelmingly, they have been shocked and offered to help you if they can as they know these allegations were not in your nature. You said that they have been incredibly supportive because they know the 'professional you' and have helped to build your confidence and self-esteem back up. You also said that some of them, including those who have known you for a short time, have shared with you their cases with the NMC or dealings that they have had when supporting others through NMC hearings. You told the panel that colleagues have been caring, trust you, and are happy to work with you.

When further pressed by the panel about how you think a fully informed member of the public would feel if you were nursing their grandmother, you said that members of the public would question your professionalism, integrity, why it happened on your watch, and would want to ensure that their loved one was going to be safe, comfortable, and cared for. However, you said that you would hope that they would know that you would do everything you can to keep them safe and well cared for. You accepted that this should never have happened and hope that people remember the good that you have done. You said that you have been open and honest. You also said that you have learnt an exceptionally valuable lesson, and it will not happen again to the best of your ability.

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

Ms Stevenson told the panel that the NMC have defined fitness to practise as the suitability to remain on the register without restriction. She reminded the panel that the NMC guidance states that the question that will help decide whether a professional's

fitness to practise is impaired is: “Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”.

Ms Stevenson submitted that the panel may be assisted by the questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of *Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant* [2011] EWHC 927 (Admin). She submitted that the panel may also wish to consider *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

Ms Stevenson submitted that the NMC submit that you are currently impaired and that the first three limbs of *Grant* are engaged.

Ms Stevenson submitted that, in light of the current findings, you have in the past and/or is liable in the future to act as so as to put a patient or patients at unwarranted risk of harm. She submitted that you placed a number of vulnerable residents at risk over a sustained period of time. However, she submitted that the panel may consider that the public protection concerns arise when you are practising as a manager and that no concerns have been raised about your own aptitude as a nurse.

Ms Stevenson submitted that, whilst you have regularly worked as a nurse since these concerns, you have not worked in a managerial role. Further, she submitted that you assert that you would not undertake a managerial role in the future and that you intend on retiring. She submitted that if you were permitted to practise unrestricted, then it is always open to you to change your mind and return to nursing or undertake a managerial role. Therefore, Ms Stevenson submitted that the panel is invited to attach less weight to your future intention in this regard.

Ms Stevenson submitted that your behaviour, as found proven, plainly brings the profession into disrepute. She submitted that there are a number of clinical concerns in wide-ranging areas and that vulnerable residents were placed at a real risk of harm. Further, that members of the public fully appraised of the failings and the findings would

expect regulatory action. Ms Stevenson also submitted that you have breached fundamental tenets of the profession in numerous areas of the Code, in that you have not practised effectively and have not promoted professionalism and trust.

Ms Stevenson submitted that the panel may consider that whilst the nature of the concerns in this case can be addressed, the concerns are wide-ranging and occurred over a period of time. Equally, since the concerns occurred, you have been practising as a nurse, albeit not a manager, and no further concerns have arisen.

Ms Stevenson submitted, in relation to whether the concerns have been addressed, that you have provided evidence as to impairment. However, she submitted that the panel has very recently heard your oral evidence and you have provided written evidence such as a reflective account and character references.

Ms Stevenson referred to a response received by the NMC from you, on 28 November 2016, which states:

> *'… I have never knowingly put anyone in danger and there are families who will give good positive feedback about the care of their loved ones… I fully understand the seriousness of the charges laid at my door and have tried to be factual and not emotional in my response to you…'.*

Ms Stevenson referred to a further response received from you on 29 May 2017, which states:

> *'… On reflective was I the right person to manage Sowerby House possibly not. I have also decided not to home manage again and return to my first love of general nursing. It is a joy to do the job that I love without the stresses and strains of management however skills and lessons learnt in management roles should enhance my knowledge for this role…'.*

Ms Stevenson referred to your reflective account dated 15 November 2018, which states:

'… Was I a perfect Home Manager – no I am human. I was stretched too far with little support… Do I believe I am fit to practice – yes I do...Do I want to manage again – no I don't. The job of manager has become so far removed from the residents that it is not what I want to do'.

Ms Stevenson further informed the panel that you have also provided oral evidence as to impairment today where you set out the contextual factors around the time that the concern arose and what you have been doing since. She acknowledged that you provided positive testimonials.

Ms Stevenson submitted that there is limited evidence of insight and remediation for the following reasons:

1. You denied the majority of the allegations and therefore, although seemingly accepting some of the allegations that have been found proved, still raised various contextual factors within your reflection of the proved charges; and

2. There is limited evidence as to what you would do differently in the future and how you have remedied the concerns.

In relation to risk of repetition, Ms Stevenson submitted that there has been limited evidence from you to assure the panel that these concerns would not be repeated in the future. She submitted that, whilst you have been working since these concerns arose, you have only been working in a nursing role and not a managerial role. Therefore, the evidence is limited as to whether you can positively put before the panel, and support with evidence, that these concerns would not happen again in the future, and that you have remedied the concerns or would act differently. Further, given the wide-ranging concerns that occurred over a period of time and the lack of insight, Ms Stevenson submitted that a risk of repetition remains.

Ms Stevenson acknowledged the evidence provided by Witness 2 as to support and the difficulties registered managers may face, and the concessions made by many of the witnesses about the organisational issues at the Home that you were not culpable for. Equally, Ms Stevenson bore in mind Witness 2's evidence that the CQC had 'concerns' about you and that they would have referred you to the NMC had the employers not done so.

For the reasons set out above, Ms Stevenson submitted that there is limited evidence upon which the panel could conclude that there has been full insight, and acceptance, remediation and that there is no longer a risk of repetition.

As such, Ms Stevenson invited the panel to find that your fitness to practise is currently impaired.

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

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively (the fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided)

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

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

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

To achieve this, you must:
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

8 Work co-operatively

To achieve this, you must:
8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

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:

10.2 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

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

To achieve this, you must:

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

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

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

To achieve this, you must:

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

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

To achieve this, you must:

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

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

To achieve this, you must:
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

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

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

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was satisfied that the above paragraphs of the Code are relevant and engaged in this context.
The panel found that your actions, in charges 1a, 1b, 2a, 2b, 2c, 2d, 4a and 4b, did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In relation to charge 1a, the panel determined that the charge was serious and posed a significant risk/impact on Resident A's dietary and fluid requirements. Specifically, the panel was concerned that your failure to manage and identify Resident A's dietary and

fluid intake prevented a proper assessment of his requirements at various times of the day and night. Therefore, your actions in this charge amounted to misconduct.

In relation to charge 1b, the panel determined that it is essential for each nurse to ensure and maintain good record-keeping as a general rule. The panel was of the view that it is particularly important for the benefit of the resident who will be cared for by a number of healthcare professionals who need to understand the resident's care needs. Therefore, your actions in this charge amounted to misconduct.

In relation to charge 2a, the panel adopted the same view as charge 1b. Therefore, your actions in this charge amounted to misconduct.

In relation to charge 2b, the panel adopted the same view as charge 1a. Therefore, your actions in this charge amounted to misconduct.

In relation to charge 2c, the panel determined that Resident B was vulnerable/in a high-risk category, and so by you failing to ensure that written guidance was completed for staff, you caused further potential risks, failed to adequately safeguard the patient, and did not share information with staff to mitigate any potential falls. Therefore, your actions in this charge amounted to misconduct.

In relation to charge 2d, the panel determined that there was no risk management plan put in place and thus adopted the same view as charge 2c. Therefore, your actions in this charge amounted to misconduct.
In relation to charge 4a, the panel determined that your failure to uphold Resident B's dignity when left to lay in faeces and urine was serious misconduct, causing the risk of pressure sores and infection to an already vulnerable resident. Therefore, your actions in this charge amounted to misconduct.

In relation to charge 4b, the panel determined that there were incomplete records over several dates for Resident B, where there were records not completed over a four-hour

period. The panel had regard to examples of your failure between 13 and 15 July 2016. Therefore, your actions in this charge amounted to misconduct.

In relation to charges 8 and 9, the panel determined that, despite the charge being found proved, it accepts what you said in that you tried your very best to ensure that training was delivered. You told the panel that training had changed to an electronic system and that not all members of staff had access to devices in order to complete the training. You raised issues of training with the company and were awaiting dates. You further told the panel that you were informed by the new provider that no funding was currently available for the training and therefore ultimately you were unable to secure training at no fault of your own. Although you had an in-house trainer that dealt with manual handling training, no other trainers were available to deliver other types of training. In light of the above, the panel determined that your failures in relation to training was due to a lack of resources which was beyond your control. Therefore, your actions in these charges did not amount to misconduct.

In relation to charge 12, the panel determined that your failure to fully engage with safeguarding was linked to your non-attendance at safeguarding meetings. The panel accepted that you were sick on one occasion, and so you could not go to that meeting and on another occasion, you went to the wrong building. The panel was of the view that the reasons for your absence on these two occasions justify why you did not fully engage with safeguarding procedures. Further, whilst the panel is aware that you could not get to these meetings, you did attend other safeguarding meetings and there is no evidence to suggest that you did not engage with safeguarding in any other form such as emails and phone calls. Therefore, your actions in this charge did not amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired. The panel had regard to the following pieces of NMC Guidance:

- ‘Impairment’ DMA-1
- ‘Insight and strengthened practice’ FtP-13
- ‘Can the concern be addressed?’ FtP-13A
- ‘Has the concern been addressed?’ FtP-13B
- ‘Is it highly likely that the conduct will be repeated?’ FtP-13C

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

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

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

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

> *‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*

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

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

The panel finds that patients were put at risk of physical and psychological harm as a result of your misconduct. In relation to whether you pose a future risk of putting patients at unwarranted risk of harm, the panel took into account that you have been practising as a registered nurse for the past seven years with no reported concerns. The panel also took into account your positive references regarding your practise, and that the references cover the period that you have been working as a registered nurse since the allegations arose. The panel noted that the references speak highly and positively about you as a nurse. The panel noted that two of your references are from current employers, both dated 10 January 2024. One Registered Home Manager at your current workplace stated:

'… As the sole nurse on duty Joanne is required to complete comprehensive documentation including risk assessments, care plans, professional visitor notes, friends and family records, progress notes, care evaluations and care plan reviews. Joanne also competes electronic medicines records. Joanne has shown an understanding of our regulatory requirements and has also acted swiftly to ensure that potential safeguarding issues are escalated and reported….

I have found Joanne's records to be timely and complete. I can easily follow her records for the care planned and delivered on shift and those records also capture and reflect changes to care. For example, when there was a change (deterioration) in condition Joanne has recorded and documented a thorough clinical assessment, she has liaised with clinicians outside the home, next of kin, revised care plans and

communicated the action plan clearly to her team. I have witnessed Joanne taking time to explain the changes in health to our residents and their families and she successfully adapted the clinician's feedback to use language that ensured they understood, they could fully participate in any decisions that needed to be made and were able to make informed choices…

Joanne also checks their records and charts and ensures that they accurately reflect the care they delivered that shift. I have heard Joanne praising staff for their record keeping and I have also heard her asking for more details (when a food chart did not include portion sizes consumed). As part of my review of records I have not identified a gap in carer records when Joanne is on duty….

I am pleased when the agency proposes Joanne for a shift as her work has always been to a good standard. I also feel reassured because she has taken time to get to know our residents and their families….'.

Another Registered Home Manager at your current workplace stated:

'Joanne would follow the recognised care plan system in operation, reviewing the activities of daily living and associated risk assessments to provide care. In the event of observed changes, Joanne would communicate this to the team and the manager on call. Detailing the needs within the care plan or writing a new car plan as required. Joanne would also notify the resident and the LPA / NOK…
Joanne would use the care plan to identify the chosen communication method with the residents. I have observed Joanne positively supporting residents, ensuring that the residents' choices were paramount in the decision making, also supporting those residents subject to a depravation of liberty ensuring that best interest decisions were made in accordance with mental capacity act…

Joanne has notified the management team when she has discovered errors in medication dispensing, anomalies in the count, missing signatures, omissions, she

has also followed the local policy, completed the incident notification, notified and apologised to the resident , next of kin / LPA. Reported to the GP / 111, maintained detailed observations and supported in the investigation process and lessons learnt….'.

However, whilst acknowledging your positive references, the panel determined that there is still a risk of repetition. The panel was of the view that in your oral evidence you failed to fully recognise the responsibility you have as a registered nurse and how those responsibilities apply equally to you as a registered nurse acting in a managerial role. As a nurse in a management role, it was your responsibility to ensure that residents were cared for to the high standard expected of registered nurses, and you were accountable for the nursing standards within the Home generally. It took into account the pressures you worked under but was also of the view that you were unable to demonstrate meaningful insight into your failings.

When asked by the panel, you did not demonstrate in your responses how you would, in the future, prevent these failings from occurring again and how your practice has been strengthened. The panel was of the view that your responses lacked depth and insight, and that for some of the failings you continued to attribute blame to your unsupportive working environment. Further, the panel found that your insight into the effect of your failures on residents under your care, families, and colleagues, is limited and you have not been able to fully demonstrate an understanding of the potential risks of serious harm to those residents and the potential impact on their future care, overall health, and their dignity. For these reasons, the panel determined that there is a risk of repetition.

Additionally, the panel is satisfied that your misconduct has in the past brought and is liable in the future to bring the nursing profession into disrepute. Your misconduct relates to a number of fundamental areas of nursing care, including areas where the personal dignity of a resident was compromised. The panel acknowledge your account that all of these concerns flow from you previously working in a non-supportive role that you found to be overwhelming. However, the panel was of the view that whilst you say that you were

unsupported in your role, as a registered nurse, you were still responsible for the residents under your care who were vulnerable, and in all probability, by reason of those vulnerabilities, less able to articulate their needs. For the above reasons, the panel is satisfied that your misconduct has in the past breached and is liable in the future to breach one of the fundamental tenets of the nursing profession.

The panel is satisfied that the misconduct in this case is capable of being addressed and is remediable. The panel noted your successful completion of mandatory training and gave very careful consideration to the references provided. However, given your lack of insight as described above, on balance, the panel is not satisfied that the concerns have been fully remediated.

In light of these circumstances, the panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

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

In relation to the public interest, the panel was of the view that a reasonable and well-informed member of the public would be concerned if a finding of impairment was not made in your case. The panel also considered that a finding of impairment is required to uphold the standards in the profession and to maintain confidence in the behaviour expected of registered nurses.

In light of these circumstances, the panel therefore determined that a finding of impairment is also necessary on the grounds of public interest.

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

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

Prior to hearing any submissions in relation to sanction, Ms Stevenson made a request that some parts of this case be held partly in private at this stage on the basis that [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004' (the Rules).

You supported this application.

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

The panel determined to go into private session in connection with [PRIVATE] as and when such issues are raised in order to [PRIVATE].

Sanction

The panel considered this case very carefully and decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

In reaching this decision, the panel 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. This included reference to the following guidance:

- ‘Factors to consider before deciding on sanctions’ – SAN-1
- ‘Considering sanctions for serious cases’ – SAN-2
- ‘Available sanction orders’ – SAN-3

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Stevenson informed the panel that in the Notice of Hearing, dated 6 July 2023, the NMC had advised you that it would seek the imposition of a suspension order for a period of 6 to 12 months with a review if it found your fitness to practise currently impaired.

Ms Stevenson submitted that being proportionate means finding a fair balance between the nurse, midwife or nursing associate’s rights and the NMC’s overarching objective of public protection.

In relation to aggravating features, Ms Stevenson submitted the following:

- The facts found proven are serious
- Lack of insight and remediation
- You were in a position of responsibility as Home Manager/Registered Manager
- A pattern of misconduct over a period of time
- The misconduct is wide-ranging
- Concerns persisted despite safeguarding meetings and warnings or concerns being raised
- The evidence suggests that the rating of the Home decreased during the time you were the manager

- A number of vulnerable residents were placed at a real risk of harm over a sustained period of time. She submitted that the NMC views patient harm extremely seriously and putting patients at risk of harm makes your failings more serious.

In relation to mitigating features, Ms Stevenson submitted the following:

- You made partial admissions
- Concessions made by many of the witnesses about the organisational issues at the Home that you were not culpable for
- Contextual factors. For example, there appears to have already been issues at the Home before you took up your position as manager
- No concerns have been raised since and you have been practising unrestricted
- Evidence of some insight and remediation
- Positive testimonials
- Evidence of training
- Engagement throughout these procedures
- [PRIVATE]

Ms Stevenson submitted that the panel found that patients were put at risk of physical and psychological harm as a result of the misconduct. She submitted that it was found you failed to fully recognise the responsibility that you have as a registered nurse and how those responsibilities apply equally to you as a registered nurse acting in a managerial role. She submitted that, as a nurse in a management role, it was your responsibility to ensure that residents were cared for to the high standard expected of registered nurses, and that you were accountable for the nursing standards within the Home generally.

Ms Stevenson submitted that it was also found you were unable to demonstrate meaningful insight into your failings and that your response lacked depth and insight. She submitted that you were unable to fully demonstrate an understanding of the potential risks of serious harm to those residents and the potential impact on their future care, overall health, and their dignity. Further, she submitted that there is a risk of repetition.

Ms Stevenson reminded the panel that for some of the failings you continued to attribute blame to your unsupportive working environment, and that the misconduct relates to a number of fundamental areas of nursing care, including areas where the personal dignity of a resident was compromised.

Ms Stevenson acknowledged that the panel also took into account the pressures that you were under and your account that all of these concerns flow from you working in a non-supportive role that you found to be overwhelming. However, she submitted that whilst you say that you were unsupported in your role, as a registered nurse, you were still responsible for the residents under your care who were vulnerable, and in all probability, by reason of those vulnerabilities, less able to articulate their needs.

Ms Stevenson submitted that taking no action and a caution order are not suitable for this case due to the seriousness of the concerns. With regards to a conditions of practice order, she submitted that conditions of practice order would not be appropriate in this case as conditions would be difficult to formulate to allay the concerns which relate to your work in a managerial capacity. She submitted that if the panel was minded to impose a condition that relates to you not being a manager, looking forward and practically, there is a question as to how long that condition would have to be in place for, and it may be necessary up until you retire.

Ms Stevenson submitted that if you are subject to a current fitness to practise sanction and wish to leave the register to retire, you are required to apply for removal by agreement from the register instead. On the other hand, she submitted that if you are not allowed to practise as a manager, there is less opportunity for you to remediate. For these reasons, she submitted that imposing conditions may be difficult to formulate.

Ms Stevenson therefore invited the panel to impose a suspension order, which was appropriate to address the seriousness of the concerns including your direct responsibility

for exposing patients to harm. She further submitted that a suspension order would be sufficient to protect patients and maintain standards.

Ms Stevenson submitted that a striking-off order was excessive in the circumstances.

The panel also bore in mind your submissions. You submitted that you understand the seriousness of the findings against you and would like to think that throughout these proceedings you have tried to fully engage and learn. You reminded the panel that the incidents occurred seven years ago whilst you were a manager and you made it clear that you do not wish to return to a managerial role. You understand that the panel could impose a condition that does not allow you to take on a managerial role as you do not intend to return to this position.

You understand that additional training is required, and you are very happy to comply with this. You understand that supervisions may be necessary which you are more than happy to abide to. You submitted that, in your opinion, your practice and documentation has improved, and you have been helpful to others.

You told the panel that if you were suspended you would retire and not pick nursing back up. You also told the panel that [PRIVATE].

In relation to potential financial impact that the imposition of a suspension order may have on you, you told the panel that [PRIVATE]. You submitted that it would be very hard for you to work in a restricted role at present as you are sometimes the only nurse in the building. However, you told the panel that there is always someone on the other end of the phone should you need support.

You told the panel that you have worked for a long time and would like to continue nursing. You said that you sometimes feel that you are not very eloquent in the way you speak but that you do take things seriously and very much to heart. You submitted that the focus

seems to be on a few incidents happening, albeit you are aware of the seriousness of your actions. You said that you take accountability for your actions, but that there were also other accountable people on duty at the time of the incidents.

You reminded the panel that the NMC has taken a long time, namely since 2016, to bring these concerns to light as you have been practising well as a registered nurse for seven years without concern.

Decision and reasons on sanction

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

- Underdeveloped insight and remediation into failings
- Registered nurse with management responsibility
- Failings over a period of time
- Failings that are wide-ranging
- Conduct which put vulnerable residents at risk of suffering harm

The panel also took into account the following mitigating features:

- Partial admissions
- Challenging work environment within the Home
- No concerns have been raised since the incidents and you have been practising in the intervening seven years without restriction

- Positive testimonials from your current agency and managers of the home that you have been working

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

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted, protect the public, and mark the public interest in this case. The panel was satisfied that you would be willing to comply with a conditions of practice order.

The panel had regard to the fact that these incidents happened over seven years ago, namely in 2015/2016. It also had regard to the fact that since these incidents, you have worked as a registered nurse without restriction and without any concern. Further, the panel had regard to your positive references from your current employers which speaks highly to your current ability as a registered nurse. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to continue to practise as a nurse.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order that will restrict you practising as a registered nurse in a managerial position, restrict your practise to working with one employment agency, and enable you to fully reflect on your failings, in order to develop better insight about the misconduct identified.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case. In reaching this view, the panel had particular regard to the positive testimonials received, and the absence of any deep-seated personality or attitudinal problems and no repeated misconduct since the incident.

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

In making this decision, the panel carefully considered the submissions of Ms Stevenson in relation to the sanction that the NMC was seeking in this case, namely a suspension order. However, given the circumstances as set out above, the panel considered that it would be disproportionate to impose a suspension order as a conditions of practice order satisfies both the public protection and public interest.

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

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

1. You must keep the NMC informed about anywhere you are working by giving your case officer your employment agency's contact details and keeping your case officer up to date if you change your agency.

2. You must immediately give a copy of these conditions to any employment agency you apply to or are registered with for work.

3. You must tell your case officer, within seven days of your becoming aware of:
    - Any clinical incident you are involved in directly or indirectly.
    - Any investigation started against you.
    - Any disciplinary proceedings taken against you.

4. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    - Any current or future employment agency.
    - Any other person(s) involved in your retraining and/or supervision required by these conditions.

5. You will send the NMC a report seven days in advance of the next NMC hearing or meeting from your employment agency.

6. You must not practise as a registered nurse:
    a. In a managerial capacity.
    b. In a private capacity.

7. You must limit your nursing practice to one employment agency.

8. You must keep a reflective practice profile. You must:
    • Discuss your practice, every three months, with a fellow registered nurse that you have been working with.
    • Keep a record of these discussions to put before a reviewing panel.
    • Send your case officer a copy of the profile every three months.

The period of this conditions of practice order is for 12 months with a review.

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

Any future panel reviewing this case would be assisted by:

- Evidence of a reflective piece which sets out your full insight into your failings. This is to include the impact your actions had on patients, families, colleagues, and the nursing profession.
- Continued engagement with NMC proceedings.
- Any up-to-date testimonials from your employment agency and managers at any home that you are working in.

- Any up-to-date training you have completed, particularly in relation to leadership and documentation.

This will be confirmed to you in writing.

Interim order

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

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

Submissions on interim order

The panel took account of the submissions made by Ms Stevenson. She submitted that an interim conditions of practice order for a period of 18 months is necessary given the panel's findings in order to protect the public and meet the wider public interest. She submitted that this was required to cover the 28-day appeal period and, if you do appeal the decision, the period for which it may take for that appeal to be heard. She submitted that the reputation of the profession would be significantly undermined if an interim conditions of practice order was not in place, and you were allowed to practise without restriction during the appeal period.

You did not oppose this application.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings.
The conditions for the interim order will be the same as those detailed in the conditions of practice substantive order for a period of 18 months to cover the 28-day appeal period and any period which an appeal may be heard.

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

That concludes this determination.