Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing

7 – 25 October 2019

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

Name of registrant:	Mrs Sharmila Kale
NMC PIN:	10E0039C
Part(s) of the register:	Registered Nurse – Sub-part 1 Adult Nursing – May 2010
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Kathryn Eastwood (Chair, Registrant member) Carla Hartnell (Registrant member) Georgina Foster (Lay member)
Legal Assessor:	Megan Ashworth
Panel Secretary:	Charlie Russell
Mrs Kale:	Not present and not represented in absence
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Facts proved:	1a, 1b, 2a, 2b, 2c, 2d, 3b, 4a, 4b, 4d, 4e, 5a, 5b, 5c, 5d, 6a, 6b, 7a, 7b, 7c, 7d, 8b, 8c, 8d, 9a, 10a, 10b, 11, 13, 14ai, 14aii, 15, 16, 17, 18b, 18e, 19, 20b, 20c, 20d, 21, 22a, 22b, 22c, 23
Facts not proved:	3a, 4c, 8a, 9b, 10c, 12a, 12b, 14aiii, 14b, 18a, 18c, 18d, 20a, 22d
Fitness to practise:	Impaired
Sanction:	Striking-off
Interim order:	Interim suspension order – 18 months

Details of charge (Amended)

That you, a registered nurse whilst employed as the manager or registered manager at Wyvern Lodge Care Home ("the Home") between November 2015 and 27 May 2016:

1) In relation to Patient 1;

a) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

b) On one or more occasions between 11 February 2016 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

2) In relation to Patient 2;

a) Did not ensure that care plans were completed adequately or at all.

b) Did not ensure that one or more of the risk assessments in Schedule 1 were completed.

c) On one or more occasions between 25 March 2016 and 14 May 2016 did not ensure that 24 hour care charts were completed or completed fully.

d) Did not ensure that admissions paperwork and/or a past medical history was completed.

3) In relation to Patient 3;

a) Did not ensure that care plans were completed adequately or at all.

b) On one or more occasions between 25 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed or completed fully.

4) In relation to Patient 4;

a) Did not ensure that one or more of the risk assessments in Schedule 1 were completed.

b) On one or more occasions between November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed or completed fully.

c) Did not ensure a referral was made to the falls team between November 2015 and March/May 2016.

d) Did not make a deprivation of liberty application in respect of Patient 4 prior to a sensor mat being put in place or, in the alternative, consent from Patient 4 for the use of a sensor mat was not recorded.

e) After bruising was noted on 2 and/or 15 and/or 19 May 2016 did not ensure that an accident form was completed and/or an investigation was carried out and/or that a safeguarding referral was made.

5) In relation to Patient 5;

a) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

b) On one or more occasions between 27 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

c) Did not ensure that a referral was made to safeguarding when it was noted that Patient 5 was withdrawing cash from the cash machine for another resident.

d) On one or more occasions between November 2015 and January 2016 did not ensure that entries on MAR charts were double signed.

6) In relation to Patient 6;

a) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

b) On one or more occasions between 21 November 2015 and 13 April 2016 did not ensure that 24 hour care charts were completed adequately or at all.

7) In relation to Patient 7;

a) Did not ensure that care plans were completed adequately or at all.

b) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

c) On one or more occasions between 25 November 2015 and May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

d) On one or more occasions between January 2016 and May 2016 did not ensure that entries on MAR charts were signed.

8) In relation to Patient 8;

a) Between 29 November 2015 and 26 December 2015 did not ensure that one or more of the medications in Schedule 2 were administered or did not ensure that the administration of the medication was recorded.

b) On one or more occasions between 25 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

c) Did not ensure that a referral was made to safeguarding when it was noted that Patient 8 was vulnerable to losing money.

d) Allowed aspirin to be regularly administered to Patient 8 when this was contraindicated because it was recorded that Patient 8 was allergic to salicylates.

9) In relation to Patient 9;

a) On one or more occasions between 25 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

b) Did not ensure a referral was made to the Speech and Language Therapy Team (“SALT”).

10) In relation to Patient 10;

a) On one or more occasions between 25 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

b) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

c) Did not ensure that care plans were completed adequately or at all.

11) In relation to Patient 11 on 5 February 2016 did not record in the controlled drugs ("CD") register that Patient 11 had been given 170mls Oramorph to take with him on discharge.

12) In relation to Patient 12 on or around 16 January 2016 did not;

a) Record in the CD register that 34 tablets of Zomorph had been given to Patient 12's daughter when Patient 12 was discharged.

b) Ask Patient 12's daughter to sign for receipt of the 34 tablets of Zomorph for Patient 12.

13) On one or more occasions between 4 April 2016 and 15 May 2016 did not ensure there were sufficient staffing levels at the Home.

14) Did not ensure safe medicines management within the Home in that;

a) On 18 and/or 19 May 2016;

i) You did not ensure that residents' medication received from Boots was checked in.

ii) You did not ensure that residents' medication was stored securely.

iii) You did not ensure that Patient 1's Adizen and/or Patient 9's Indapamide and/or Patient 5's simvastatin were recorded in the Drugs Disposal Book;

b) There was no British National Formulary available at the Home.

15) Did not ensure that residents' records were stored securely.

16) In May 2016 provided a copy of a training certificate to Care Quality Commission Inspector 1 for training on 2 April 2016 which you did not complete and/or which you did not receive a training certificate for.

17) Your conduct in Charge 16, above, was dishonest in that you knew you did not complete the training for which you provided the certificate.

18) Did not ensure that fundamental care was provided to residents in that;

a) The GP was not called in a timely manner when residents reported feeling unwell.
b) Between March 2016 and May 2016 Patient 2 was often not provided her call bell in the morning so that she was unable to call for assistance.
c) Between March 2016 and May 2016 an unknown resident often changed himself after covering himself in urine.
d) Residents were not showered or bathed regularly enough.
e) Residents' nutritional needs were not adequately met.

19) Did not ensure that staff at the Home were adequately trained in that one or more carers were not adequately trained in one or more of the areas set out in Schedule 3.

20) Did not ensure that there was an adequate recruitment process place in that:

a) HCA1 commenced employment at the Home prior to a Disclosure and Barring Service check being completed.
b) References were obtained from previous employers who had not been declared in the staff member's application form.
c) Gaps in employment of staff members were not checked.
d) One or more carers did not receive a proper induction to the Home.

21) Did not ensure that equipment was maintained and/or audited safely in that quality control assessments for glucometer devices were not audited and/or recorded.

22) Did not ensure that a safe environment was maintained in the Home in that:

a) One or more residents who were at risk of falls were placed in rooms which opened onto a landing with stairs with no gate.
b) The Home was not compliant with fire safety regulations.
c) There was no adequate cleaning rota in place at the Home.
d) Dishes were not cleaned adequately.

23) On 27 May 2016 left your post at the Home without first arranging adequate cover to maintain the safety of the residents.

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

Schedule 1

Falls risk assessment
Mobility risk assessment
Barthel risk assessment
General risk assessment
Waterlow risk assessment
Nutrition risk assessment

Schedule 2

Aspirin
Metformin

Omeprazole
Simvastatin
Thiamine
Vitamin B compound
Zuclopenthixol
Tamsulosin

Schedule 3

Blood sugar monitoring
Epilepsy
Moving and handling
Medications administration
Mental Capacity Assessments/Deprivation of Liberty Safeguards

Service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Kale was not in attendance and was not represented in her absence.

In the absence of Mrs Kale, the panel first considered whether the Notice of Hearing had been served in accordance with Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules"). In doing so, it took account of submissions made by Mr Edwards and the information provided to it.

The panel was informed that the Notice of Hearing letter had been sent to Mrs Kale's registered address by recorded delivery and by first class post on 5 September 2019. The panel had regard to the Royal Mail 'Track and Trace' printout which showed that the Notice of Hearing was returned to sender on 25 September 2019, after its retention period had exceeded.

The panel took into account that the Notice of Hearing provided details of the allegations, the times, dates and venue of the hearing and, amongst other things, information about Mrs Kale's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

Mr Edwards submitted that the Nursing and Midwifery Council (NMC) had complied with the requirements of Rules 11 and 34 of the Rules.

The panel accepted the advice of the legal assessor in relation to service of notice who confirmed for the panel that Notice of Hearing letter contained the required particulars, including the time and venue for this hearing. The legal assessor further confirmed that the Notice of Hearing letter has been served in accordance with the requirements of Rules 11 and 34. The legal assessor reminded the panel that delivery is not a requirement for service.

In the light of all of the information available, the panel was satisfied that Mrs Kale has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34. It noted that the rules do not require delivery.

Proceeding in the absence of Mrs Kale

The panel next considered whether it should proceed in the absence of Mrs Kale.

The panel had regard to Rule 21 (2), which states:

> *(2) Where the registrant fails to attend and is not represented at the hearing, the Committee—*
>
> *(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;*

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.

Mr Edwards confirmed for the panel that the NMC had made numerous attempts to seek engagement with Mrs Kale about this hearing between April and October 2019. He informed the panel that Mrs Kale provided a response letter to the allegations, but apart from that has not engaged with her regulator save for an email, dated 7 May 2019, where Mrs Kale made no mention of whether she wished to attend this hearing or not.

Mr Edwards submitted that further correspondence was sent to Mrs Kale on 6 and 9 September 2019. Both pieces of correspondence had been refused and returned to sender. Mr Edwards informed the panel that a trace inquiry was carried out by the NMC to determine whether Mrs Kale had changed address. However, it was confirmed that Mrs Kale remained at her registered address on the NMC Register.

In all the circumstances, Mr Edwards invited the panel to continue in the absence of Mrs Kale on the basis that she had voluntarily absented herself from these proceedings. He informed the panel that no application has been made by Mrs Kale to adjourn this hearing and submitted that there was no reason to believe that an adjournment would secure her attendance at a future date. Mr Edwards submitted that the NMC intend to call six witnesses, including an expert witness, to give live evidence at this hearing. Further, Mr Edwards submitted that the allegations against Mrs Kale are serious, and there is a strong public interest in these proceedings being dealt with expeditiously.

The panel took account of the legal assessor's advice and was reminded that the discretion to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and must be exercised with the utmost care and caution in accordance with the case of *R.* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

In deciding whether to proceed in the absence of Mrs Kale, the panel weighed Mrs Kale's right to attend this hearing and be legally represented against its duties to protect the public and the expeditious disposal of the case. The panel noted its discretionary power to proceed in the absence of a registrant as referred to in the case of *Jones*.

The panel has decided to proceed in the absence of Mrs Kale. In reaching this decision, the panel has considered the submissions of Mr Edwards, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162. The panel has also had regard to the overall interests of justice and fairness to all parties. It noted that:

- on 12 April 2019, Mrs Kale had been emailed with possible dates for a hearing and would therefore have known her case would proceed to a hearing;
- no application for an adjournment has been made by Mrs Kale;
- Mrs Kale has not engaged with the NMC since May 2019 and has not responded to any of the letters sent to her about this hearing;
- there was no good reason for adjourning and there was nothing before the panel to suggest that Mrs Kale would attend on some future occasion, were it minded to adjourn this hearing;
- six witnesses are due to give live evidence, not proceeding may inconvenience these witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- the charges relate to events that occurred between 2015 and 2016 and any further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- there is a strong public interest in the expeditious disposal of the case.

The panel acknowledges that there is some disadvantage to Mrs Kale in proceeding in her absence, although the evidence upon which the NMC relies has been sent to her at her registered address. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on her own behalf. However, in the

panel's judgment, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross examination and, of its own volition, it can explore any inconsistencies in the evidence which it identifies. Furthermore, the disadvantage is the consequence of Mrs Kale's decisions to absent herself from the hearing, waive her right to attend and/or be represented and to not provide evidence or make submissions on her own behalf.

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

Application to amend charge pursuant to Rule 28 of the Nursing and Midwifery Fitness to Practise Rules 2004 ("the Rules")

The panel heard an application made by Mr Edwards, on behalf of the NMC, to amend the wording of charges 4(d), 8(d), 17 and 18(b):

4) In relation to Patient 4;

d) A deprivation of liberty application was not made in respect of Resident H prior to a sensor mat being put in place or, in the alternative, consent from Resident H for the use of a sensor mat was not recorded.

8) In relation to Patient 8;

d) Allowed aspirin to be regularly administered to Resident G when this was contraindicated because it was recorded that Resident G was allergic to salicylates.

17) Your conduct in Charge 17, above, was dishonest in that you knew you did not complete the training for which you provided the certificate.

18) Did not ensure that fundamental care was provided to residents in that;

b) Between March 2016 and May 2016 Patient 10 was often not provided her call bell in the morning so that she was unable to call for assistance.

The proposed amendment to charge 4(d) was to amend the wording to read:

4) In relation to Patient 4;

d) **Did not make a** deprivation of liberty application ~~was not made~~ in respect of ~~Resident H~~ **Patient 4** prior to a sensor mat being put in place or, in the alternative, consent from ~~Resident H~~ **Patient 4** for the use of a sensor mat was not recorded.

The proposed amendment to charge 8(d) was to amend the wording to read:

8) In relation to Patient 8;

d) Allowed aspirin to be regularly administered to ~~Resident G~~ **Patient 8** when this was contraindicated because it was recorded that ~~Resident G~~ **Patient 8** was allergic to salicylates.

The proposed amendment to charge 17 was to amend the wording to read:

17) Your conduct in ~~Charge 17~~ **Charge 16**, above, was dishonest in that you knew you did not complete the training for which you provided the certificate.

The proposed amendment to charge 18(b) was to amend the wording to read:

18) Did not ensure that fundamental care was provided to residents in that;

b) Between March 2016 and May 2016 ~~Patient 10~~ **Patient 2** was often not provided her call bell in the morning so that she was unable to call for assistance.

The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

28.—(1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend—

(a) the charge set out in the notice of hearing; or

(b) the facts set out in the charge, on which the allegation is based,

unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.

(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.

The panel was of the view that such amendments, as applied for, were in the interests of justice. The panel was satisfied that there would be no prejudice to Mrs Kale and no injustice would be caused to either party by the proposed amendments being allowed. The panel considered the amendments to charges 8(d), 17 and 18(b) were simply to address typographical errors which, when amended, did not alter the meaning or mischief of what is alleged. The amendment to charge 4(d) was to specify Mrs Kale's personal responsibility in relation to the charge. It was therefore appropriate for the amendments to be made to ensure clarity, accuracy and fairness to Mrs Kale.

Application to hear the evidence of Mr 6 via telephone

Following directions given by the panel, Mr Edwards told the panel that the NMC had been able to establish contact and communication with Mr 6. Mr 6 had previously confirmed to the NMC that he would attend this hearing to provide live evidence in person. However, Mr 6 did not attend this hearing as arranged on Tuesday 8 October, nor did he contact the NMC to explain his non-attendance. The NMC was given from Friday 12 October to 10am Monday 14 October to try to contact Mr 6 to explore the potential to give live evidence via video-link, the panel's preference, or by telephone. Mr Edwards explained to the panel that in order to assess the application, it would need to see the communications with Mr 6 to obtain a full picture conceding that the tone of Mr 6's emails was 'fraught'. Mr 6 notified the NMC that he was unable to give live evidence via video-link, but that he was in a position to give live evidence over the telephone.

Mr Edwards therefore made an application under Rule 31 to allow Mr 6 to provide evidence to the panel via telephone. In the preparation of this hearing, the NMC had indicated to Mrs Kale in the case management form that it was intended that Mr 6 would provide live evidence to the panel in person. Mr Edwards submitted that his evidence was both relevant and, despite Mrs Kale's absence, the panel would be in a position to test his evidence. On this basis, Mr Edwards advanced the argument that there was no lack of fairness to Mrs Kale in allowing Mr 6 to give evidence over the telephone.

The panel accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 of the Rules provides that, so far as it is '*fair and relevant,'* a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel gave the application with regards to Mr 6's oral evidence serious consideration. It considered that the nature and tone of Mr 6's correspondence with the NMC indicated a reluctance to attend to give evidence in person. However, it noted that

Mr 6's statement had been prepared in anticipation of being used in these proceedings. It was signed by Mr 6 on 9 September 2019 and he had signed within it that he was willing to attend and give evidence.

Mr 6 was the Acting Deputy Manager of the Home and worked with Mrs Kale for a short period of time. Mr 6 had direct contact with Mrs Kale, patients and staff at the Home. He was subject to the management processes within the Home. In light of the above, the panel considered that Mr 6's evidence was clearly relevant.

The panel considered whether Mrs Kale would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony in person of Mr 6 to that of a telephone call. It considered that there is some material difference between the hearing of oral evidence in person and oral evidence via telephone; the panel would not be able to visually assess the demeanour of Mr 6.

The panel considered that Mrs Kale had been provided with a copy of Mr 6's statement in advance of the hearing. Given her voluntary absence, she would not be in a position to cross-examine this witness. However, the panel was satisfied that it was important to explore this relevant evidence and test it as far as possible, keeping in mind the limitations.

In these circumstances, the panel concluded that it would be fair and relevant to accept Mr 6's evidence via telephone, but would give this evidence what it deemed to be appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

Mrs Kale is a Registered Nurse and was the Registered Manager of Wyvern Lodge Care Home ("the Home") between November 2015 and 27 May 2016. Her husband was the Registered Provider. It is alleged that she had been in post as the Unregistered

Manager for three months prior to taking up the position of Registered Manager. The Home had between 11 and 13 patients at the time of the alleged incidents.

On 1 March 2016, a complaint was made to North Somerset Council ("the Council") by email by a relative of a patient at the Home, complaining of the standard of care. Following the complaint, a member of the Contracts and Compliance Team (CCT) at the Council visited the Home. A number of concerns were identified, following which the CCT visited regularly up until May 2016.

The Council alerted the Care Quality Commission (CQC) about its concerns, including safeguarding concerns. The Council also alerted Environmental Health who visited on 31 March 2016 and Avon Fire and Rescue Service, who visited on 24 May 2016.

The CQC conducted an inspection of the Home over the days of 18, 19, 23 and 26 May 2016, after serious concerns were raised about the Home, including poor risk assessment, care planning and provision, understaffing, lack of mandatory training, record keeping and medication administration. During their visits, the CQC spoke with patients and staff, examined documents and made contemporaneous notes of what they observed during the inspection. The CQC also liaised with other professionals such as the fire service and the local authority who had attended the Home previously.

During the inspection, the Lead Inspector was shown a certificate of mandatory training relating to Mrs Kale being provided training on 2 April 2016 by the Mandatory Training Group ("the Group"). It is alleged that Mrs Kale did not complete the training, and that the certificate provided to the inspector was not a certificate provided by the Group. It is alleged that Mrs Kale's actions were dishonest.

It is alleged that once the CQC made clear its concerns, Mrs Kale appeared to abandon the patients in her care over the May 2016 bank holiday weekend by leaving the Home, forcing the CQC into taking emergency measures to protect the patients. The CQC made an application to the Magistrates Court to close the Home down on 27 May 2016.

A CQC inspection report was published on their website on 6 October 2016.

The CQC seized a large volume of documentation, including the patient records of patients one to 10. Following an expert's analysis of the records, it is alleged that there were a number of failures in record keeping and provision of care, which is the subject of charges one to 10.

Findings on facts

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Mr Edwards, on behalf of the NMC. It also considered the written representations received from Mrs Kale.

The panel accepted the advice of the legal assessor, who referred the panel to the case of *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 in relation to considering the operational, managerial role and its relationship to the role of the registered professional. She also referred the panel to the case *Ivey v Genting Casinos* [2017] UKSC 67, in respect of dishonesty.

She further advised the panel of the case of *Lawrence v GMC [2015] EWHC 586 Admin,* in which it was said: that panels *"should only find dishonesty established if they were satisfied that there was cogent evidence of dishonesty. The civil standard applies, but where dishonesty or a particularly a serious offence is alleged, the decision makers must be aware of the need for such cogent evidence*".

The burden of proof rests upon the NMC and Mrs Kale does not have to prove anything. The standard of proof is the civil standard, namely the balance of probabilities. This means that, for a fact to be found proved, the NMC must satisfy the panel that what is alleged to have happened is more likely than not to have occurred. In determining the

facts, the panel is entitled to draw inferences provided there is an evidential basis for them, but not to speculate.

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

Witnesses called on behalf of the NMC were:

Ms 1 – Specialist-Professional Advisor on CQC inspection (Nurse);
Mr 2 – Director of the Mandatory Training Group, accredited provider of statutory and mandatory training;
Ms 3 – North Somerset Council Contracts and Commissioning Team Service Leader;
Ms 4 – Expert Witness;
Ms 5 – CQC Lead Inspector;
Mr 6 – Acting Deputy Manager of the Home.

The panel first considered the overall credibility and reliability of all of the witnesses it had heard from.

Ms 1

The panel considered that Ms 1 was credible and reliable. It considered that Ms 1 was an experienced Registered Nurse who made contemporaneous notes of her visits to the Home as part of the CQC inspection, which informed her subsequent NMC written statement. The panel considered Ms 1's evidence to be consistent, in her contemporaneous notes, NMC written statement and oral evidence and did not speculate when she could not recall.

Mr 2

The panel considered that Mr 2 was credible and reliable. Mr 2 was able to provide helpful and professional knowledge, speaking to the specific charge 16. Mr 2 did not

appear to waiver or speculate during his oral evidence. Overall, the panel considered that Mr 2 had a good recall of events, and was able to reference contemporaneous email correspondence and documentation consistent with his account.

Ms 3

The panel considered that Ms 3 was credible and reliable. The panel noted Ms 3's role within the Council, and considered that she had extensive knowledge of what is suitable and what is not in a care home setting. She also visited the Home and so had direct knowledge of certain events and Mrs Kale herself, although the panel noted that Ms 3 was not always able to be specific in her answers and sometimes spoke for what she had been told, rather than what she had directly experienced. Nonetheless, Ms 3 did not attempt to elaborate on her findings.

Ms 4

The panel considered that Ms 4 was the expert for the NMC who gave professional, articulate and balanced answers to the panel. The panel noted a discrepancy in Ms 4's expert report and her oral evidence to the panel. She was asked in terms of whether the documentation she had been provided on which to base her expert report included the CQC report. She told the panel that she had no access to the CQC report and it did not inform any part of her expert report. However, her expert report referenced the CQC report and some of its findings. Given that the findings of the CQC report were negative about the Home, and rated it as 'inadequate', the panel was mindful to the risk that this may have affected the expert's independence. It therefore carefully explored her approach and methodology and cross referenced the source material from which she arrived at her opinions. She had not speculated, and there were areas in her report which identified areas of good practice. In all the circumstances, the panel was satisfied that Ms 4 remained balanced, independent and maintained her credibility as an expert witness.

Ms 5

The panel considered Ms 5 to be credible and reliable. Initially, the panel found that Ms 5 struggled with her recall, however once she had time to refresh her memory from her CQC report and Statement of Reasons document provided to the Magistrates Court on 27 May 2016, this seemed to enable her to respond confidently to panel questions. The panel found that Ms 5 was structured and fair in her answers and was not drawn on any matters which had not been evidenced. She was very clear about the evidence based within her report, and how it had been quality assured to ensure that any findings were based on evidence. Ms 5 was also clear about Mrs Kale's accountability and legal responsibility in being registered as the Registered Manager of the Home.

Mr 6

Mr 6 was the Acting Deputy Manager of the Home at the relevant time. He was employed for six weeks, initially beginning employment as a Health Care Assistant (HCA) before being moved to Acting Deputy Manager. The panel noted a number of inconsistencies in Mr 6's evidence. It found that Mr 6 was, at times, evasive, opinionated and lacked credibility. Some of his evidence, in the panels view, was not plausible, and a number of areas of his statement were contradictory in themselves. In his signed NMC written statement, dated 9 September 2019, Mr 6 indicated that he was currently studying to be a Registered Nurse. Mr 6 told the panel that this statement was true and accurate to the best of his knowledge and belief, however when pressed, it came to light that Mr 6 was not currently studying to be a Registered Nurse. His explanation for it appearing in his signed NMC written statement was that he had not read those paragraphs. While the panel acknowledged Mr 6's role within the Home, it decided to approach his evidence with a degree of caution. The panel would look to see if there was other supportive evidence before accepting his account.

The panel considered each charge and made the following findings:

The panel noted that a number of the charges were framed in terms of Mrs Kale "did not ensure". In respect of whether she had a duty to ensure certain actions were carried out, the panel had regard to the evidence of Ms 5 and Ms 1.

Ms 5 told the panel that Regulation 8 of the Health and Social Care Act 2008 (HSCA 2008) says: "A registered person must comply with regulations nine to 19 in carrying of a registered activity. She explained that this meant that Mrs Kale had a legal responsibility to ensure the service met the legal requirement as set out in the HSCA 2008 and had a responsibility for the oversight and delivery of care to service users within the Home on a day to day basis. Ms 1 told the panel that Mrs Kale was responsible and accountable for record keeping within the Home. Record keeping is integral to safe and effective care. The panel had regard to this evidence in respect of each charge which is alleged "did not ensure".

Charge 1:

1) In relation to Patient 1;

   a) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel took into account the expert evidence of Ms 4, including her oral evidence and Nursing Practice Report, dated 11 September 2019. In addition, the panel had sight of the patient notes which informed Ms 4's expert report.

In determining the level of responsibility, if any, Mrs Kale had in ensuring that the risk assessments set out in Schedule 1 were completed adequately or at all, the panel heard evidence that Mrs Kale was the only Registered Nurse within the Home. She was also the Registered Manager. The panel was satisfied that, while she may delegate

tasks, Mrs Kale had ultimate responsibility in ensuring that risk assessments were completed adequately within the Home.

Once the panel had established Mrs Kale's level of responsibility in relation to this charge the panel referred to Ms 4's expert evidence. In her oral evidence, Ms 4 confirmed for the panel that Mobility, Barthel, Waterlow, Falls and Nutrition risk assessments are all mandatory risk assessments to be completed upon admission and updated monthly thereafter. Ms 4 concluded in her report that there were no risk assessments for Mobility, Barthel, General and Waterlow in respect of Patient 1.

The panel had access to Patient 1's notes. It saw no evidence to indicate that Mobility, Barthel, General and Waterlow risk assessments had been completed at all. This supported the expert evidence of Ms 4. For these reasons, the panel was satisfied that Mrs Kale did not ensure that one or more of the risk assessments in Schedule 1 were completed at all.

Accordingly, the panel finds this charge proved.

b) On one or more occasions between 11 February 2016 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

The panel found this charge proved.

As above, the panel was satisfied that Mrs Kale had a responsibility to ensure 24 hour care charts were completed. In reaching this decision, the panel considered the expert evidence of Ms 4.

The panel noted that Ms 4 told the panel that 24 hour care charts were not mandatory, but drew together a number of care areas. She said that not every care home uses such

a tool to collect and record the information, but that nonetheless information did need to be collected and this was the tool that this care home had adopted.

The panel took into account Ms 4's expert report, specifically section 6.9.9, which states that for Patient 1: "24 hour care charts are available from 11/02/16, and are completed until 15/05/16. They give information about a broad range of care needs (see chronology above). There are, however, gaps in the documentation on a total of 30 days out 94".

The panel also had sight of Patient 1's notes, which included incomplete 24 hour care charts. This supported the expert evidence of Ms 4. For these reasons, the panel was satisfied that Mrs Kale did not ensure on one or more occasions between 11 February 2016 and 15 May 2016 that 24 hour care charts were completed adequately in respect of Patient 1.

Accordingly, the panel finds this charge proved.

Charge 2:

2) In relation to Patient 2;

a) Did not ensure that care plans were completed adequately or at all.

This charge is found proved.

As above, the panel was satisfied that Mrs Kale had a responsibility to ensure that care plans were completed.

The panel had regard to Ms 4's expert report, in particular section 7.4.1, which states in respect of Patient 2: *"There is no evidence that I can see of any care plans being completed."*

The panel also had sight of Patient 2's notes and saw no evidence of any care plans being completed for this patient. This supported the expert evidence of Ms 4. For these reasons, the panel was satisfied that Mrs Kale did not ensure that care plans were completed at all for Patient 2.

Accordingly, the panel finds this charge proved.

b) Did not ensure that one or more of the risk assessments in Schedule 1 were completed.

This charge is found proved.

The panel had regard to Ms 4's expert report, in particular section 7.9.2, which states in respect of Patient 2: *"There are…no mandatory risk assessments".*

The panel took into account Ms 4's evidence that all of the risk assessments set out in Schedule 1 except for the General risk assessment are mandatory risk assessments to be completed on admission and updated monthly thereafter.

The panel accepted the expert evidence of Ms 4 and was satisfied that Mrs Kale did not ensure that risk assessments of Falls, Mobility, Barthel, Waterlow and Nutrition were completed.

Accordingly, the panel finds this charge proved.

c) On one or more occasions between 25 March 2016 and 14 May 2016 did not ensure that 24 hour care charts were completed or completed fully.

This charge is found proved.

In reaching this decision, the panel considered the expert report of Ms 4, specifically section 7.5.2, which states in respect of Patient 2: "*The first chart to be completed was on 25/03/16 and they run until 14/05/16, a total of 50 days. The charts are incomplete on 20 days of the 50 days that they have been completed. This includes all of the charts in May 2016."*

The panel also had regard to section 7.9.5, which states: *"24 hour care charts are available from 25/03/16 and they run until 15/05/16…There are 20 days of the 50 days they have been completed that are incomplete".*

The panel accepted the expert evidence of Ms 4, and was satisfied that Mrs Kale did not ensure on one or more occasions between 25 March 2016 and 14 May 2016 that 24 hour care charts were completed fully in respect of Patient 2.

Accordingly, the panel finds this charge proved.

> d) Did not ensure that admissions paperwork and/or a past medical history was completed.

This charge is found proved.

In reaching this decision, the panel considered the expert report of Ms 4, specifically section 7.7.1, which states in respect of Patient 2: *"There is no evidence that I can see of admission paperwork or past medical history being completed".*

The panel also had sight of Patient 2's notes. It was aware that any past medical history paperwork would be included in Patient 2's admission paperwork. The panel saw no evidence of any admission paperwork or past medical history being completed. This supported the expert evidence of Ms 4. For these reasons, the panel was satisfied that Mrs Kale did not ensure that admissions paperwork or a past medical history was completed in respect of Patient 2.

Accordingly, the panel finds this charge proved.

Charge 3:

3) In relation to Patient 3;

a) Did not ensure that care plans were completed adequately or at all.

This charge is found NOT proved.

In reaching this decision, the panel took account of Ms 4's expert report, specifically section 8.4.1, which states in respect of Patient 3: *"Comprehensive care plans have been written on admission to Wyvern Lodge and updated monthly. They have been updated monthly over the time that Nurse Kale was manager of Wyvern Lodge."*

The panel also had regard to section 8.9.4, which states: *"Care plans have been written and a monthly evaluation has been completed thereafter up until discharge. All risk assessments have been completed".*

When questioned during her oral evidence, Ms 4 confirmed for the panel that 'comprehensive' care plans for Patient 3 were completed and updated monthly during the time that Mrs Kale was in post as the Registered Manager of the Home. The panel considered that Ms 4 gave robust evidence in relation to this. Further, the panel had sight of Patient 3's notes and saw evidence to indicate that Mrs Kale did ensure that care plans were completed adequately for Patient 3. This supported the expert evidence of Ms 4. For these reasons, the NMC had not discharged the burden of proving that Mrs Kale did not ensure that care plans were completed adequately or at all.

Accordingly, the panel found this charge not proved.

b) On one or more occasions between 25 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed or completed fully.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 8.5.2, which states in respect of Patient 3: *"These are first completed on 25/11/15 and continue to 15/05/15 a total of 172 days…They are incomplete on 25 occasions, including every day in May 2016".*

The panel also had regard to section 8.9.5, which states: *"24 hour care charts are completed from 25/11/15 until discharge on 15/05/15. They give information about a broad range of care needs. There are, however, 25 days…where the charts are incomplete".*

The panel accepted the expert evidence of Ms 4 and was satisfied that Mrs Kale did not ensure on one or more occasions between 25 November 2015 and 15 May 2016 that 24 hour care charts were completed fully in relation to Patient 3.

Accordingly, the panel finds this charge proved.

Charge 4:

4) In relation to Patient 4;

a) Did not ensure that one or more of the risk assessments in Schedule 1 were completed.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 9.4.7, which states: *"There are no evidence that I can see of Waterlow risk assessments being completed".*

The panel also hard regard to section 9.9.4, which states: *"All risk assessments have been completed with the exception of the Waterlow risk assessment. This is a mandatory risk assessment".*

The panel accepted that there is evidence to suggest that four of the five risk assessments had been completed. However, the panel bore in mind that the Waterlow risk assessment is mandatory and had not been completed. In light of this, the panel was satisfied that Mrs Kale did not ensure that one of the risk assessments in Schedule 1, namely Waterlow, was completed.

Accordingly, the panel finds this charge proved.

b) On one or more occasions between November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed or completed fully.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically 9.5.2, which states: *"24 hour care charts have been completed from November 2015 up until discharge from the home on 15/05/16*". Ms 4 reports that the documentation is incomplete on 24 of the 142 days.

The panel also had regard to section 9.9.5, which states: *"24 hour care charts are available from 25/11/15 until discharge in May 2016. They give information about a broad range of care needs. Of the 171 pages of documentation, there are 24 days of incomplete charts".*

The panel accepted the expert evidence of Ms 4 and was satisfied that Mrs Kale did not ensure on one or more occasions between November 2015 and 15 May 2016 that 24 hour care charts were completed fully in respect of Patient 4.

Accordingly, the panel finds this charge proved.

c) Did not ensure a referral was made to the falls team between November 2015 and March/May 2016.

This charge is found NOT proved.

In reaching this decision, the panel considered the expert report of Ms 4, specifically section 9.6.2, which states: "*Referral was made to the falls team in March 2016, and had to be followed up by staff when she had not been seen by May 2016, despite numerous falls throughout Pt. 4's stay in Wyvern Lodge*". Ms 4, in the chronology of care for Patient 4 noted for 29 April 2016, *"…follow up falls team required…"; and for 3 May 2016, "contacted falls team about Pt 4's referral…"*

According to the patient notes, it appears a referral was made on 14 March 2016. The NMC had not discharged the burden of proof that Mrs Kale did not ensure a referral was made to the falls team.

Accordingly, the panel finds this charge not proved.

d) Did not make a deprivation of liberty application in respect of Patient 4 prior to a sensor mat being put in place or, in the alternative, consent from Patient 4 for the use of a sensor mat was not recorded.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's chronology of Patient 4's notes for 18 May 2016, which records: *"Pt. 4 has sensor mat whilst asleep staff must ensure to attend to Pt 4 as soon as alarm goes off…".*

The panel also had regard to Ms 1's NMC written statement, specifically: *"As I say the Falls Team had recommended the use of a sensor mat. However, in my clinical notes, I made a note that* "the mat was placed under her sheet, rustled continuously and appeared to be slippery with sheet on top. It appeared an odd place as most mats are on the floor beside the bed." *When I questioned the registrant about the mat, she realised she should have submitted a Deprivation of Liberty application"*

She went on to say: *"[The registrant] said she had requested an IMCA (Independent Mental Capacity Advocate) as this lady had no NOK (next of kin) and was investigating if this resident had an allocated social worker. The IMCA is a role created by the Mental Capacity Act 2005. A duty lies with a local council or NHS body to involve an IMCA in circumstances where a vulnerable person lacks mental capacity and needs to make a decision about serious medical treatment or an accommodation move".*

The panel accepted Ms 1's evidence that a sensor mat was used for Patient 4, albeit in the wrong place. The panel was satisfied from the evidence that the purpose of a sensor mat is that it deprives an individual's freedom of movement by alerting staff each time the patient moves. Ms 1 told the panel that in order to use a sensor mat, either the patient's consent for it must be sought, or if it is not clear whether the patient has capacity to consent, a Mental Capacity Assessment (MCA) is to be carried out to determine whether or not an individual is deemed to lack capacity with regard to certain aspects of their daily life. If it is determined the individual lacks capacity, then a DoL's application is required to be submitted, prior to using such a mat.

The panel noted Ms 1's NMC written statement, specifically: "I reiterate that I saw no record of any mental capacity assessment being undertaken".

The panel also took into account Ms 5's NMC written statement, specifically: *"We could find no DoLS applications within the paperwork we found".*

The panel was satisfied that if Patient 4 did had capacity then her consent was required to use the mat and if she lacked capacity, then a DoL(Deprivation of Liberty)'s application was required.

The panel is satisfied that there is evidence to confirm that a sensor mat was used in respect of Patient 4. Given that there is no record of any DoL's application or MCA paperwork found within the Home, the panel concluded that consent from Patient 4 for the use of a sensor mat was not recorded and no DoL's application was made before the sensor mat was put in place.

Accordingly, the panel finds this charge proved.

e) After bruising was noted on 2 and/or 15 and/or 19 May 2016 did not ensure that an accident form was completed and/or an investigation was carried out and/or that a safeguarding referral was made.

This charge is found proved.

In reaching this decision, the panel considered the NMC written statement of Ms 5, specifically: *"Pt. 4 alleged she had been physically manhandled by staff. She said staff had dragged her into the shower and that was how she had the bruises on her back… I asked her [Mrs Kale] why she did not complete an investigation into Patient 4 ' fall at the time of the bruising being discovered. The body map was dated 2 May 2016. We could not make sense of her response. She did not know what she should be notifying to us in line with statutory obligations. Registered managers should know the process around safeguarding".*

The panel also considered the NMC written statement of Ms 1, specifically: *"When I was speaking to Patient 4 I noticed she had a roundish shaped bruise on her right hand… I do not think the registrant really understood what was expected of her or how to navigate her roles and responsibilities in this safeguarding context of care."*

Ms 5's NMC written statement also stated that there was no entry by Mrs Kale on the body map. *"By not having a manager's response on the body maps it was not clear if she was aware, if the marks had been investigated, and if she had taken action to keep the person safe. The registrant had not taken action in respect of this incident and there had been no information sharing with the local authority safeguarding team or the CQC".*

From all the evidence before it, the panel was satisfied that Mrs Kale did not ensure that an investigation was carried out, nor that a referral was made to safeguarding. Further, given that Mrs Kale appeared unaware of her responsibilities, the panel was also satisfied that it was more likely than not that Mrs Kale did not ensure that an accident form was completed. In light of the above, the panel finds this charge proved, on the balance of probabilities.

Charge 5:

5) In relation to Patient 5;

a) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 10.4.3, which states: *"There is no evidence that I can see of mobility risk assessments being completed".* It also took into account section 10.4.7, which states: *"There is no*

evidence that I can see of any Waterlow risk assessments being completed". The panel reminded itself that Mobility and Waterlow risk assessments are both mandatory.

The panel accepted the evidence of Ms 4 and was satisfied that Mobility and Waterlow risk assessments had not been completed at all. The panel therefore finds this charge proved.

b) On one or more occasions between 27 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report regarding 24 hour care charts for Patient 5, specifically section 10.5.2, which states: *"These have been completed from 27/11/15 to 15/05/16. Over this time, there are 31 occasions where the charts are not fully completed".*

The panel accepted the evidence of Ms 4. It was satisfied that Mrs Kale did not ensure that on 31 occasions during this period, the care charts in respect of Patient 5 had been completed adequately.

For these reasons, the panel finds this charge proved.

c) Did not ensure that a referral was made to safeguarding when it was noted that Patient 5 was withdrawing cash from the cash machine for another resident.

This charge is found proved.

In reaching this decision, the panel considered the expert report of Ms 4, specifically section 10.6.2, which states: *"Pt. 5 was withdrawing cash from the cash machine for another resident. This should have been dealt with as a safeguarding concern for Pt.5 and for the other resident involved, to ensure that there was no risk of financial abuse. No safeguarding referral was made".*

The panel also had regard to section 10.9.10, which states: *"Pt. 5 had been using another resident's bank card to withdraw cash for him at the cash machine. This should have been highlighted as a safeguarding concern, because Pt. 5 and the other resident were both at risk of financial abuse".*

The panel accepted the evidence of Ms 4 that in these circumstances of potential financial abuse, a referral to safeguarding was required, and that there was no record to indicate that such a referral had been made.

Accordingly, the panel finds this charge proved.

d) On one or more occasions between November 2015 and January 2016 did not ensure that entries on MAR charts were double signed.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 10.9.2, which states: *"There are some hand written MAR charts in November 2015, December 2015 and January 2016 that have not been signed. These should have two signatures. When medications are hand written onto a MAR chart in the care home, they should be checked and signed by two people to ensure accuracy. These signatures should be in the left hand box where the medication is recorded. I am unsure whether these entries have been written by Nurse Kale".*

When questioned during her oral evidence, Ms 4 confirmed for the panel that she would expect to see a second signature to ensure accuracy for handwritten medication added to a Medication Administration Record (MAR) chart, part way through the medication cycle. The panel accepted Ms 4's expert opinion. As such, the panel was satisfied that Mrs Kale had a duty, as a Registered Nurse and the Registered Manager, to ensure that entries on MAR charts were double signed.

The panel also had sight of Patient 5's MAR charts between November 2015 and January 2016. These MAR charts had handwritten medication added to them and therefore require a second signature. The panel saw evidence of a single signature however, the panel saw no evidence of a second signature. This supported the expert evidence of Ms 4. For these reasons, the panel was satisfied that Mrs Kale did not ensure that entries on MAR charts were double signed on one or more occasions between November 2015 and January 2016.

Accordingly, the panel finds this charge proved.

Charge 6:

6) In relation to Patient 6;

a) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 11.4.7, which states: *"There is no evidence that I can see of a Waterlow risk assessment being completed".*

The panel also took into account section 11.9.5, which states: *"I cannot find any Waterlow risk assessment within the bundle provided to me, and there is only one mobility risk assessment. The Waterlow risk assessment is mandatory".*

The panel accepted Ms 4's expert evidence that there was no evidence of a Waterlow risk assessment completed between November 2015 and 27 May 2016. The panel was satisfied that Mrs Kale did not ensure that the Waterlow risk assessment listed in Schedule 1 was completed at all.

Accordingly, the panel finds this charge proved.

b) On one or more occasions between 21 November 2015 and 13 April 2016 did not ensure that 24 hour care charts were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 11.5.2, which states: *"Completed from 21/11/15 until 13/04/16 when Patient 6 was discharged home. There are 12 occasions that the 24 hour care charts are incomplete".*

The panel also had regard to section 11.9.6, which states: *"24 hour care charts are available from November 2015 until discharge on 13/04/15. They give information about a broad range of care needs. There are, however, 12 occasions where the charts are incomplete".*

The panel accepted the expert evidence of Ms 4. It considered incomplete 24 hour care charts on 12 occasions to be inadequately completed, and Mrs Kale did not ensure they were completed adequately. For these reasons, the panel finds this charge proved.

Charge 7:

7) In relation to Patient 7;

a) Did not ensure that care plans were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 12.4.1, which states: *"There is no evidence that I can see of care plans being completed from November 2015 to May 2016".*

The panel accepted the expert evidence of Ms 4 and checked the patient records of Patient 7 and found no care plans within them. The panel was satisfied that Mrs Kale did not ensure that care plans were completed at all for Patient 7. Accordingly, the panel the panel finds this charge proved.

b) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered the expert report of Ms 4, specifically section 12.9.4, which states: *"There are no care plans available for this patient and no mandatory risk assessments".*

The panel accepted the expert evidence of Ms 4. The panel was satisfied that Mrs Kale did not ensure that the mandatory risk assessments, namely Mobility, Barthel, Waterlow and Nutritional, were completed.

Accordingly, the panel finds this charge proved.

c) On one or more occasions between 25 November 2015 and May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 12.5.1, which states: *"These charts commence on 25/11/15 and run until May 2016. As with previous chronologies, there are incomplete charts, and all of the charts in May 2016 are incomplete".*

The panel accepted the expert evidence of Ms 4. It considered that 24 hour care charts, including all care charts in May 2016, to be inadequately completed. The panel was therefore satisfied that Mrs Kale did not ensure that 24 hour care charts were adequately completed.

For these reasons, the panel finds this charge proved.

d) On one or more occasions between January 2016 and May 2016 did not ensure that entries on MAR charts were signed.

This charge is found proved.

The panel noted that Ms 4, in her oral evidence, conceded that the MAR chart recordings were generally good.

The panel also had sight of Patient 7's notes. There were MAR charts available relating to the months of November and December 2015 and January, March, April and May 2016 but noted the experts evidence that in light of the other MAR charts completed, it was likely that this MAR chart was missing, rather than any medication not having been given. For many of the weeks, the panel also noted that medications were described as 'none' supplied this cycle. The panel established that the only entries not signed for as

having been administered related to a nutritional supplement. Nonetheless, this was not signed for. Given that the wording of this charge requires that on 'one or more' occasions between January 2016 and May 2016 Mrs Kale did not ensure that entries on MAR charts were signed, the panel therefore finds this charge proved in respect of prescribed nutritional supplements.

Charge 8:

8) In relation to Patient 8;

a) Between 29 November 2015 and 26 December 2015 did not ensure that one or more of the medications in Schedule 2 were administered or did not ensure that the administration of the medication was recorded.

This charge is found NOT proved.

The panel noted Ms 4's expert report, specifically section 13.3.1, which states: *"There is a blank MAR chart between 29/11/15 and 26/12/15. The MAR charts for the month before and up until discharge…have been completed in their entirety. There are also two MAR charts for the administration of PRN paracetamol".*

The panel also had regard to section 13.9.1, which states*: "There is a blank MAR chart between 29/11/15 and 26/12/15 suggesting that aspirin, metformin, omeprazole, simvastatin, thiamine, and vitamin B compound, zuclopenthixol, and tamsulosin have not been given over this four week period. The MAR charts for the month before and up until discharge after this date have been completed in their entirety to a reasonable standard. There are also two MAR charts for the administration of PRN paracetamol".*

The panel also had regard to section 13.9.3: *"It is, however, my opinion that it is unlikely that a full month of medications have been missed when all other MAR charts have been completed accurately".*

When questioned during her oral evidence, Ms 4 told the panel that given that the other MAR charts for this patient were completed to a reasonable standard, it was her expert opinion that it was more likely than not that the medication had been administered to Patient 8 between 29 November and 26 December 2015, and that the MAR chart for this period was 'missing'.

The panel had sight of Patient 8's MAR charts between 29 November and 26 December 2015. There was a blank chart as Ms 4 had described. However, the panel also saw evidence that there were completed MAR charts for the weeks commencing 29 November 2015 and 4 December 2015. The panel heard evidence that there had been a change of pharmacy, moving to Boots around this time and a change of type of MAR charts used. The panel accepted the expert opinion of Ms 4 that it was unlikely that a full month of medication had been missed. The NMC had not discharged the burden of proof that Mrs Kale did not ensure that the medications were administered between 29 November 2015 and 26 December 2016. Further, given that the panel have seen completed MAR charts up until 11 December, the NMC had not discharged the burden of proof that Mrs Kale did not ensure that the administration of medication was recorded for that time.

Having regard to the above, the panel finds this charge not proved.

b) On one or more occasions between 25 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 13.5.2, which states: *"These are completed from 25/11/15 until 15/05/16. As with previous chronologies, there are incomplete charts, with no complete charts throughout May 2016".*

The panel accepted the expert evidence of Ms 4. It was satisfied that Mrs Kale did not ensure that the 24 hour care charts were adequately completed.

Accordingly, the panel finds this charge proved.

c) Did not ensure that a referral was made to safeguarding when it was noted that Patient 8 was vulnerable to losing money.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 13.6.2, which states: *"When it was recognised that Patient 8 was vulnerable to losing money, this should have been highlighted as a safeguarding concern. This should have been done by alerting the safeguarding team of the concern. They are then in a position to offer support and advice to the care home on how to best manage the situation."*

The panel also had regard to section 13.9.9, which states: *"A risk assessment for handling money was completed on 22/03/16, when it was recognised that Patient 8 may be vulnerable to losing money, and handing his cash card to other residents to take money out for him. This should have been raised as a safeguarding issue to prevent any likelihood of financial abuse. This should have been done by alerting the safeguarding team of the concern. They are then in a position to offer support and advice to the care home on how to best manage the situation. I cannot find any evidence that this was done".*

The panel accepted the evidence of Ms 4 that, in these circumstances, where a risk assessment had concluded that Patient 8 was vulnerable to losing money, a safeguarding referral was required. Given that there is no evidence that this was referred to safeguarding, the panel was satisfied that Mrs Kale did not ensure that a

referral was made to safeguarding when it was noted that Patient 8 was vulnerable to losing money.

Accordingly, the panel finds this charge proved.

d) Allowed aspirin to be regularly administered to Patient 8 when this was contraindicated because it was recorded that Patient 8 was allergic to salicylates.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Ms 1, specifically: *"I reviewed a number of MAR charts during my visit to the home. Of significant concern to me was the MAR chart for Patient 8. On top of the MAR prescription sheet in the 'Allergies' box had been handwritten 'salicylates', spelt incorrectly but easily recognised. Directly underneath this the resident had been prescribed Aspirin regularly by the GP and it had been repeatedly administered…When I raised this with the registrant she said that the GP had prescribed the aspirin, that she was unaware that aspirin was a salicylate and that the resident was not allergic to it. She was about to put a line through this when I asked her how she could be sure and that she required written evidence before altering the MAR chart. I was concerned she had been about to do this as she had no evidence to substantiate her statement that he was not allergic to salicylates. I informed her that she needs to confirm this with the GP which she did on 19 May 2016…".*

The panel accepted the evidence of Ms 1 that salicylates are a major ingredient in aspirin, and so aspirin should not be administered to a patient who is allergic to salicylates.

The panel also considered the expert evidence of Ms 4. During her oral evidence, Ms 4 confirmed for the panel where she would expect to see any allergies recorded on a patients' MAR chart.

The panel had sight of Patient 8's MAR charts. Although, it saw no evidence of an allergy to salicylates being recorded on any of the MAR charts it had access to, it accepted the evidence of Ms 1, supported by her contemporaneous notes, that she had seen such a MAR chart. In the MAR charts seen by the panel, aspirin was recorded as being administered both before Mrs Kale started as Registered Manager of the Home and while she was Manager. This supported Ms 1's evidence. The panel was satisfied that Mrs Kale had allowed Aspirin to be administered to Patient 8 regularly and accordingly finds this charge proved.

Charge 9:

9) In relation to Patient 9;

a) On one or more occasions between 25 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 14.5.2, which states: *"These are completed from 25/11/15 until 15/05/16. As with previous chronologies, there are incomplete charts. All of the charts for May 2016 are incomplete".*

The panel accepted the expert evidence of Ms 4. The panel was satisfied that Mrs Kale did not ensure that the 24 hour care charts had been completed adequately.

Accordingly, the panel finds this charge proved.

b) Did not ensure a referral was made to the Speech and Language Therapy Team (“SALT”).

This charge is found NOT proved.

In reaching this decision, the panel was mindful that the only evidence in respect of this charge came from Mr 6. His NMC written statement had been incorrectly redacted to refer to Patient 8, but Mr Edwards confirmed that the original name in the statement was that of Patient 9. According to the anonymisation key.

The panel reminded itself of its assessment of Mr 6’s credibility as a witness, and that it should approach his evidence with caution and look to see whether there was evidence to support his account. In doing so, it considered the expert evidence of Ms 4, which contradicted the evidence of Mr 6. During her oral evidence, having checked Patient 9’s notes, Ms 4 confirmed for the panel that she identified nothing to indicate that a SALT referral was required for this patient.

The panel noted this was the professional opinion of the NMC expert witness, whereas Mr 6 was not a Registered Nurse. The NMC had not discharged the burden of proof that a SALT referral was required in this case.

Accordingly, the panel finds this charge not proved.

Charge 10:

10) In relation to Patient 10;

a) On one or more occasions between 25 November 2015 and 15 May 2016 did not ensure that 24 hour care charts were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 15.5.2, which states: *"These charts have been completed from 25/11/15 up until 15/05/16. There are incomplete charts, and there are no complete charts for the month of May 2016".*

The panel accepted the expert evidence of Ms 4. The panel was satisfied that Mrs Kale did not ensure that the 24 hour care charts had been completed adequately.

Accordingly, the panel finds this charge proved.

b) Did not ensure that one or more of the risk assessments in Schedule 1 were completed adequately or at all.

This charge is found proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 15.8.5, which states: *"There are some gaps in the risk assessments".*

The panel had sight of Patient 10's notes and saw evidence of gaps in the required monthly updating of the Barthel, Mobility and Falls risk assessments. This supported the expert evidence of Ms 4. The panel accepted the expert evidence of Ms 4. It was satisfied that Mrs Kale did not ensure that the Barthel, Mobility and Falls risk assessments were completed adequately.

Accordingly, the panel finds this charge proved.

c) Did not ensure that care plans were completed adequately or at all

This charge is found NOT proved.

In reaching this decision, the panel considered Ms 4's expert report, specifically section 15.4.1, which states: *"Care plans have been written and updated monthly until April 2016".*

The panel also took into account section 15.8.5, which states: *"The care plans are well written and have been updated monthly as would be the expectation".*

The panel accepted the expert evidence of Ms 4 and considered that there is evidence to the effect that there are 'well written' care plans for Patient 10, which have been updated monthly as expected. The NMC has not discharged the burden of proof of proving that Mrs Kale did not ensure that care plans were completed adequately or at all.

Accordingly, the panels finds this charge not proved.

Charge 11:

> 11) In relation to Patient 11 on 5 February 2016 did not record in the controlled drugs ("CD") register that Patient 11 had been given 170mls Oramorph to take with him on discharge.

This charge is found proved.

In reaching this decision, the panel had regard to Ms 1's NMC written statement, specifically that Oramorph: *"at strength 10mg in 5ml is no longer required to be recorded within the controlled drugs register but, in practice, most care homes and nursing homes still store and record it as a controlled drug…Although no controlled drugs were in the locked cupboard, the register indicated that 170mls of oromorph [sic] had not been used as at 5 February 2016. When I raised this with the registrant she reported that they had given Patient 11 the bottle with the 170mls in it to take home on*

discharge. She reported that this was witnessed at the time by 'a carer'. There were no signatures in the register at the time."

Ms 1 then says: *"If this was being given to the resident to take away…this should have been clearly stated on the page of the controlled drug register at the time…".*

When questioned during her oral evidence, Ms 1 told the panel that the Home continued to treat Oramorph as a controlled drug by recording it in the CD register. Ms 1 confirmed that when she had challenged Mrs Kale about the lack of signatures in the CD register, Mrs Kale reported that this was witnessed by a carer and proceeded to amend the CD register to reflect this. The panel accepted Ms 1's evidence that she had witnessed both Mrs Kale and the carer sign the CD register retrospectively as 'at 5 February 2016'. It noted that Ms 1 attended the Home on 18 and 19 May 2016, some four months after the 170mls of Oramorph had been given to Patient 11 on discharge.

The panel acknowledged that it is no longer a requirement to store and record Oramorph as a controlled drug. However, the evidence has satisfied the panel that the Home continued to treat it as such and, in such circumstances, as a Registered Nurse and the Registered Manager of the Home, Mrs Kale had a duty to ensure that on 5 February 2016 it was recorded in the CD register that Patient 11 was given 170mls of Oramorph to take with him on discharge. It was after being asked about this by Ms 1, some four months later, that Mrs Kale recorded that the Oramorph had been given.

Having regard to the above, the panel was satisfied that on 5 February 2016 Mrs Kale did not record in the CD register that Patient 11 had been given 170mls Oramorph to take with him on discharge.

Accordingly, the panel finds this charge proved.

Charge 12:

12) In relation to Patient 12 on or around 16 January 2016 did not;

a) Record in the CD register that 34 tablets of Zomorph had been given to Patient 12's daughter when Patient 12 was discharged.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the evidence of Ms 1 and noted that there was no evidence to support this charge.

In Ms 1's contemporaneous notes of her attendance at the CQC inspection on 18 and 19 May 2016, it was recorded in the CD register: "Patient 12 had Zomorph 20mg capsules given to Patient 12's daughter leaving the correct balance of '0'. Again, the signatures of the administration were utterly illegible". In her NMC written statement, Ms 1 said that this related to 34 Zomorph capsules.

Given that there is evidence to confirm that it was recorded in the CD register that 34 tablets of Zomorph had been given to Patient 12's daughter and that there were signatures confirming this in the CD register, albeit they were illegible, the NMC had not discharged the burden of proof that there was no such record.

Accordingly, this charge is found not proved.

b) Ask Patient 12's daughter to sign for receipt of the 34 tablets of Zomorph for Patient 12.

This charge is found NOT proved.

In reaching this decision, the panel had regard to the evidence of Ms 1 and the Home's medicines policy.

The panel noted Ms 1's NMC written statement in which she stated that Patient 12's daughter 'did not countersign' to confirm that she had taken the 34 tablets of Zomorph home with her mother, Patient 12. However, it did not appear to the panel that the daughters' signature for receipt of the tablets was required, according to the NMC Standards for Medicines Management. Section 8 states:

> *"Although normally the second signatory should be another registered health care professional…in the interest of patient care, where it is not possible, a second suitable person who has been assessed as competent may sign."*

The panel also referred to the Home's medicines policy which had been provided to it. The policy did not indicate any circumstances in which it would be appropriate for a relative to sign for receipt of a controlled drug.

The panel has seen no evidence to the effect that there was a requirement for Mrs Kale to ask that Patient 12's daughter sign for receipt of the 34 tablets of Zomorph for Patient 12. The NMC has not discharged the burden of proving this charge.

Accordingly, the panel finds this charge not proved.

Charge 13:

> 13) On one or more occasions between 4 April 2016 and 15 May 2016 did not ensure there were sufficient staffing levels at the Home.

This charge is found proved.

In approaching this charge, the panel noted that it must first consider what would constitute 'sufficient' staffing levels within the Home. In doing so, the panel considered the evidence of Ms 1 and the expert evidence of Ms 4, who had access to staffing rotas in place at the Home between 4 April and 15 May 2016.

In her oral evidence, Ms 1 referred the panel to the Barthel Index dependency tool. She explained that the Barthel Index dependency tool assesses functional independence in patients to determine the degree of assistance required. Ms 1 indicated that staffing levels are determined by the degree of dependency of patients. When asked what she would consider to be 'sufficient' staffing levels, Ms 1 gave an estimate of a minimum of three carers during the day and two during the night, although this would be subject to the dependency needs of individual patients, meaning more carers may be required.

Upon analysing the staffing rotas in place at the Home between 4 April and 15 May 2016, Ms 4, in her expert report, determined that while there was evidence of the Barthel Index dependency tool being used at the Home, there was no evidence that she could find: *"to suggest that the findings were used to establish appropriate staffing levels".* When asked what she would consider to be 'sufficient' staffing levels, Ms 4 also gave an estimate of three carers during the day and two during the night, subject to the dependency needs of individual patients.

The panel accepts both the evidence of Ms 1 and the expert opinion of Ms 4 in relation to 'sufficient' staffing levels at the Home.

In considering the importance of sufficient staffing levels, the panel noted the contents of the CQC report, which looked at staffing levels, particularly over the period of the inspection: 18, 19, 23 and 26 May 2016. The CQC reported that that patients at the Home: *"were not supported by sufficient members of staff".* During their inspection, the CQC had information gained from conversations with members of staff. It was reported that one staff member had informed the CQC that they had worked 39 hours in the space of three days. It was reported that another had completed 230 hours in the space of three weeks. The CQC raised concerns that patients' needs were not being met and that patient safety was at risk.

The panel further considered Ms 1's NMC written statement regarding speaking to staff when she visited on 18 and 19 May 2016, specifically: *"Carer 'B' also spoke to me about her working hours. She was categorical that the staff did not undertake a 12 hour day shift followed by a 12 hour night shift without a break of several hours. However, she could admit to having completed a 12 hour day shift followed by a sleep-in on call. 'B' said she did not get disturbed when she did these sleep-in shifts".* The panel considered that information gained from staff conversations portrays an environment in which staff within the Home were under pressure to work. The panel itself looked through the staffing rotas which had been provided to it, and had regard to Ms 4's analysis of these rotas. Using the objective minimum numbers of three carers during the day and 2 carers during the night as the measure of sufficiency, the panel was satisfied that the staffing levels were insufficient on the following days: 10, 17 to 30 April, 1, 9 to 11, 14 and 15 May 2016. As the Registered Manager of the Home, the panel was satisfied that Mrs Kale had a duty to ensure that there were sufficient staffing levels within the Home between this period, to meet patient needs and to ensure patient safety.

For all these reasons, the panel finds this charge proved.

Charge 14:

14) Did not ensure safe medicines management within the Home in that;

a) On 18 and/or 19 May 2016;

i) You did not ensure that residents' medication received from Boots was checked in.

This charge is found proved.

In reaching this decision, the panel accepted the evidence of Ms 1. Ms 1 attended the Home on 18 and 19 May 2016, days one and two of the CQC inspection. She was clear and detailed in her evidence that she had witnessed that: *"Boots the chemist had*

delivered two large zipped bags containing the supply of medicines for all the residents for the next month. There were unsealed (zip only) and in an open, unlocked office… I opened these bags and there appeared to be no record of anyone checking what was contained within them. They contained clearly dispensed medications".

Ms 1 goes on to say: *"Of the two days I was there the home office was frequently empty, unlocked and with the door wide open and the medicines still there, unchecked and unsecure…Our inspection started on 18 May 2016. As I say, I was present on 18 and 19 May 2016 and these medicines were still in the large blue zipped bags they were delivered in and dumped in the insecure office. And there was nothing indicating that they had been 'checked in'."*

The panel also noted the contents of the CQC report, where it is reported that 'no checks' had been made to ensure that the delivery of the medications were correct.

The panel reviewed the Home's medicines policy in place as at 18 and 19 May 2016 and identified the checking in process within the policy, specifically section A, which stipulates:

> *"4. When the new drugs arrive the Registered Nurse will :*
>
> > *4.1 Check them against the M.A.R Sheets and the previous month's blister pack…"*

The panel considered that the Home's medicines policy in place on 18 and 19 May 2016 was clear about the correct procedure to follow on receipt of medication from the pharmacy and checking in the medication.

The panel accepted the evidence of Ms 1 and the findings in the CQC report that no checking in process had been followed, as was required by the Home's policy, in relation to the two bags of medication delivered from Boots. As a Registered Nurse and

the Registered Manager of the Home on 18 and 19 May 2016, the panel was satisfied that Mrs Kale had the duty to ensure that residents' medication received from Boots was 'checked in', and by not doing so, she did not ensure safe medicines management within the Home.

Accordingly, the panel finds this charge proved.

ii) You did not ensure that residents' medication was stored securely.

This charge is found proved.

In reaching this decision, the panel had regard to Ms 1's evidence that she had witnessed: *"two large zipped bags containing the supply of medicines for all the residents for the next month. They were unsealed (zip only) and in an open, unlocked office".* When questioned during her oral evidence, Ms 1 remained consistent about this. She confirmed for the panel that there was 'no effort' to secure patients' medication. When Ms 1 asked Mrs Kale about this, Mrs Kale responded that they "had no room". The panel noted the CQC report that there were 'suitable storage facilities' for medicines within the Home.

The panel reviewed the Home's medicines policy in place on 18 and 19 May 2016, specifically section B, which stipulates:

"*1. MEDICINES / CURRENT BLISTER PACKS:*

1.1 All drugs and medicines are stored in the medicine trolley which is locked to the wall in the medicines room on the ground floor of the home.

1.2 Controlled and surplus drugs are stored in the medicines room on the ground floor of the home. The room, cupboards and refrigerator are locked at all time, and the keys are ONLY held by the Registered Nurses."

The panel bore in mind that Mrs Kale was the only Registered Nurse within the Home, as well as the Registered Manager. As such, the panel was satisfied that Mrs Kale had a duty to ensure that patients' medication was stored securely.

The panel accepted the evidence of Ms 1 that on two days of visiting the Home, the patients' medication delivered from Boots was not stored securely. The panel was satisfied that by not ensuring that patients' medication was stored securely, Mrs Kale, as a Registered Nurse and the Registered Manager, did not ensure safe medicines management within the Home.

Accordingly, the panel finds this charge proved.

iii) You did not ensure that Patient 1's Adizen and/or Patient 9's Indapamide and/or Patient 5's simvastatin were recorded in the Drugs Disposal Book;

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Ms 1 and the Home's medicines policy on 18 and 19 May 2019, specifically section F which stipulates:

"3 Records of all drugs / medicines for disposal are kept in a bound Drugs Disposal Book. Separate sections of the Drugs Disposal Book, will be used for Controlled Drugs"

Section 1.3 states that the Drugs Disposal Book is kept in the treatment room and that the pharmacy representation will verify the returned medications by signing the Drugs Disposal Book.

As such, the panel was of the view that this part of the policy placed a duty on Mrs Kale, as a Registered Nurse and the Registered Manager, to ensure that all three patients' medication was recorded in the Drugs Disposal Book.

The panel also took account of Ms 1's NMC written statement, in particular*: "There were three medications in Trolley 2 which were not recorded in the register. Adizen for Patient 1, Indapamide for Patient 9, and Simvastatin for Patient 5".* In Ms 1's contemporaneous notes she recorded that "*unused or discarded drugs*" were said to be recorded with a locked second empty drugs trolley adjacent to the other drugs trolley. Within this there is a register with supposed details of any drug contained within this trolley. The panel concluded from the evidence that it appeared that the 'register' described by Ms 1 was not the same as the Drugs Disposal Book as mentioned in the policy. The panel did not have a copy of the entries in the Drugs Disposal Book for 18 and 19 May 2016, nor did any witness refer to the entries in the Drugs Disposal Book.

Given that the particular wording of this charge alleges that Mrs Kale did not ensure that the medications were recorded in the Drugs Disposal Book, the panel was not satisfied that the NMC had met the burden of proof, on the balance of probabilities, that Mrs Kale did not ensure that Patient 1's Adizen and/or Patient 9's Indapamide and/or Patient 5's simvastatin were recorded in the Drugs Disposal Book on 18 and/or 19 May 2016.

Accordingly, the panel finds this charge not proved.

b) There was no British National Formulary available at the Home.

This charge is found NOT proved.

In reaching this decision, the panel acknowledged the evidence of Ms 1 and Mr 6 that a paper copy of the British National Formulary was not available at the Home. However, Ms 1 accepted that the British National Formulary is accessible electronically.

Ms 1 told the panel that she would expect to see a paper copy of the British National Formulary available at the Home for staff to refer to. However when questioned, Ms 1 confirmed that she had not explored with staff whether they were able to access this information electronically, and therefore whether the British National Formulary would be available to them electronically.

The panel bore in mind that the burden of proof was on the NMC. It sought to rely on the evidence of Ms 1 and Mr 6 which was to the effect that there was no paper copy of the British National Formulary available at the Home. However, as enquiries into accessing the British National Formulary electronically were not made, the NMC had not adduced sufficient evidence to satisfy the panel that there was no British National Formulary available at the Home.

In these circumstances, the panel was not satisfied that the NMC had proved its case and shown, on the balance of probabilities, that Mrs Kale did not ensure that there was a British National Formulary available at the Home.

Accordingly, the panel finds this charge not proved.

Charge 15:

15) Did not ensure that residents' records were stored securely.

This charge is found proved.

The panel heard evidence from Ms 1, Ms 3, Ms 5 and Mr 6 that patients' records were not stored securely within the Home. The evidence identified several areas within the Home where patients' records were kept; the office, dining area and the lounge.

In her NMC written statement, Ms 1 stated: *"finding daily record sheets containing information on the residents' day was difficult. We found many jumbled in the bottom drawer of a filing cabinet that was in a public dining area".*

Ms 1 also referred to patients' records being stored in the office on shelves where they were not secure. In her statement, she said the door was 'constantly open', compromising patients' personal information. She also stated: *"This is in direct contravention of data protection and of the Code, Standard 5, 'Respect people's right to privacy and confidentiality".*

As such, the panel was of the view that Mrs Kale had a duty, as a Registered Nurse and the Registered Manager of the Home, to ensure that patient records were stored securely.

The panel took into account Ms 5's NMC written statement, specifically*: "When I asked to inspect the service user care notes, I was pointed to a filing cabinet of three drawers labelled care plans. It was full of just single sheets of paper that had not been filed. We were directed to the second cabinet where there was no filing system and that's when we realised it was just chaos".*

The panel also took account of Mr 6's NMC written statement, in particular: *"The care plans were pointless. They were all kept in the lounge in an unlocked filing cabinet."* While the panel maintained a degree of caution before accepting Mr 6's account, it noted that his evidence in relation to this charge is supported by other witnesses which the panel considers to be credible and reliable. The panel was satisfied that it could rely on Mr 6's evidence on this point.

Taking the above into account, the panel found this charge to be proved, on the balance of probabilities.

Charge 16:

16) In May 2016 provided a copy of a training certificate to Care Quality Commission Inspector 1 for training on 2 April 2016 which you did not complete and/or which you did not receive a training certificate for.

This charge is found proved.

In its consideration of this charge, the panel adopted the following approach. Firstly, it considered whether Mrs Kale had completed the mandatory training, secondly whether she received a certificate for training on 2 April 2016 and thirdly, whether she provided a copy of a certificate to the CQC Inspector, Ms 5 in May 2016.

In determining whether Mrs Kale completed the mandatory training on 2 April 2016, the panel took into account the evidence of Mr 2. Mr 2 was clear in his evidence that Mrs Kale did not attend the training on 2 April 2016. The panel noted his NMC written statement, specifically that Mrs Kale: *"stood for about 10 minutes or so. I remember her going away and she never returned to the training at all on that day".* When challenged during his oral evidence, Mr 2 remained consistent about this. In addition, Mr 2 was able to provide a list of those who attended the training on 2 April 2016; Mrs Kale did not feature. The panel accepted Mr 2's evidence that Mrs Kale did not complete the mandatory training on 2 April 2016.

In determining whether Mrs Kale received a training certificate for the mandatory training, the panel had regard to Mr 2's evidence, and the contemporaneous email trail regarding the request to Mr 2 that he provide a certificate of training. On 20 May 2016, Mrs Kale's husband had written to Mr 2's training company to request that a certificate be issued for Mrs Kale. He was informed that no certificate would be issued as Mrs Kale had not attended the training. The panel was satisfied that Mrs Kale was not issued with a certificate for the mandatory training of 2 April 2016.

The panel then went on to determine whether Mrs Kale provided a copy of a training certificate to CQC Inspector 1 in May 2016. The panel identified CQC Inspector 1 as Ms 5. It had regard to Ms 5's NMC written statement, in particular: *"The registrant provided me with a copy of a training certificate. It was a photocopy which was unusual as it was her own training."* As a result of her concerns, Ms 5 contacted the Mandatory Training Group on 20 May 2016, where it was confirmed to her that Mrs Kale did not attend the training and did not receive a training certificate for it. The panel accepted Ms 5's account, which remained consistent with her oral evidence. As such, the panel determined that Mrs Kale did provide CQC Inspector 1 with a training certificate in May 2016, for training on 2 April 2016 which she did not complete and for which she had not received a training certificate from the Mandatory Training Group.

Accordingly, the panel finds this charge proved.

Charge 17:

> 17) Your conduct in Charge 16, above, was dishonest in that you knew you did not complete the training for which you provided the certificate.

This charge is found proved.

In reaching this decision, the panel took into account the advice of the legal assessor, who referred it to the test of dishonesty as set out in *Ivey v Genting Casinos (UK)* [2017] UKSC 67 and *Lawrence v GMC [2015]* EWHC 586 Admin.

The panel had sight of an email, dated 20 May 2016, from Mrs Kale's husband to Regal Training. The email reads:

> *"We would like kindly request you to issue the certificate for whole training for Sharmila Kale as the refreshment mandatory training have taken place on Saturday 2nd April 2016.*

Sharmila Kale was present as I…was also present and I can confirm that…Please issue the certificate for her"

The panel had already determined that Mrs Kale did not attend the training on 2 April 2016 and did provide a falsified training certificate to CQC Inspector 1 which had not been issued by the Mandatory Training Group. The panel was satisfied that Mrs Kale knew she had only attended the first 10 minutes of introductions for the training on 2 February 2016, and that consequently she knew she was not entitled to a certificate from the Mandatory Training Group.

The panel was of the view that Mrs Kale's actions were premeditated and deliberate. Initially, she sought to obtain a certificate for training from the Mandatory Training Group which she knew she did not attend. In the email of 20 May 2016 to Ms 5, sent by Mr 2's colleague at the Mandatory Training Group and into which Mr 2 was 'cc'd', it was stated: *"My understanding from both trainers…was that although she was present for the first 10 minutes or so of the training, she did not attend for the rest of the day and she was not certified by ourselves. In fact, for the past few days she and other staff members have been calling us trying to obtain her certificate".* Given that the Mandatory Training Group did not provide a training certificate to Mrs Kale, but a purported photocopied certificate was provided to Ms 5 by Mrs Kale, the panel was satisfied that the photocopied certificate had been falsified.

The panel considered whether ordinary honest people would think that providing a falsified training certificate to a CQC Inspector, certifying completion of mandatory training, was dishonest. By providing a falsified training certificate to CQC Inspector 1, the panel was in no doubt that Mrs Kale's actions would be viewed as dishonest by the standards of ordinary honest people.

Accordingly, the panel finds this charge proved.

Charge 18:

18) Did not ensure that fundamental care was provided to residents in that;

While the panel considered the sub-charges within charge 18 individually, it made the following observations which it considered were applicable to the entirety of the charge.

Each component part to this charge involves fundamental care. The panel was satisfied that escalating concerns about the wellbeing of patients to a GP (18a), a call bell to enable patients to call for assistance (18b), hygiene (18c and 18d) and nutrition (18d) are all parts of fundamental care.

The panel was satisfied that Mrs Kale had a duty, as a Registered Nurse and the Registered Manager of the Home, to ensure that all the component parts of fundamental care identified in the charge had been carried out effectively.

The panel then went on to consider the sub-charges within charge 18 individually and made the following findings:

a) The GP was not called in a timely manner when residents reported feeling unwell.

This charge is found NOT proved.

In reaching this decision, the panel considered the hearsay statement of a Health Care Assistant (HCA 2) within the Home, referred to in the NMC written statement of Ms 3. HCA 2 reported that: *"A GP was not always being called straight away when residents have stated that they feel unwell".*

The panel bore in mind that the burden of proof was on the NMC. The NMC had relied upon the hearsay statement from a carer at the Home whose evidence the panel was

not able to test or clarify in relation to this charge. The panel has seen no evidence to ascertain what is considered to be a 'timely manner'. Further, the panel has seen no evidence to determine whether a GP was necessarily required or the time frame in which a GP should be called when patients reported feeling unwell. Given that the charge is not particularised to identify any particular patients for whom a GP was required but not called in a timely manner, the panel was not satisfied that the NMC had proved its case and shown, on the balance of probabilities, that Mrs Kale did not ensure that the GP was called in a timely manner when patients reported feeling unwell.

Accordingly, the panel finds this charge not proved.

b. Between March 2016 and May 2016 Patient 2 was often not provided her call bell in the morning so that she was unable to call for assistance.

This charge is found proved.

In reaching this decision, the panel considered the evidence of Ms 1 and Mr 6. Ms 1 had described Patient 2 as having mobility needs, and required two members of staff when moving or being moved. While the panel was aware of its earlier assessment of Mr 6's credibility and reliability as a witness, it noted that Mr 6 was consistent on this point and had a good recall of Patient 2. His evidence as to Patient 2 requiring assistance was consistent with that of Ms 1. For these reasons, the panel was satisfied that it could rely on Mr 6's evidence in its consideration of this charge.

The panel had regard to Mr 6's NMC written statement, in particular: *"Residents were not always given their call bells…Pt. 2 was the main one but the call bell was not given to her in the morning often."* The panel considered that Mr 6 did not waiver during his oral evidence in relation to this.

While Mr 6 is the only witness who speaks to Patient 2 not being provided her call bell specifically, Ms 1 does indicate in her NMC written statement that Patient 2: *"should*

have two helpers when moving or being moved. She had a hoist in her room which should have two carers to use but the daughter reported that her mother had never been put in it." The panel saw evidence to indicate that Patient 2 clearly required a way of seeking assistance from care staff due to her mobility issues and therefore had a need for a call bell.

Having regard to the above, the panel was satisfied that, between March and May 2016, Patient 2 was often not provided her call bell in the morning so that she was unable to call for assistance, as a result of her mobility issues. Mrs Kale, as a Registered Nurse and the Registered Manager of the Home, had a duty to ensure that systems were in place to enable patients to call for assistance as required, for example by way of a call bell. By not ensuring that Patient 2 was provided with a call bell, Mrs Kale did not ensure that fundamental care was provided to Patient 2.

Accordingly, the panel finds this charge proved.

c) Between March 2016 and May 2016 an unknown resident often changed himself after covering himself in urine.

This charge is found NOT proved.

In reaching this decision, the panel considered the evidence of Mr 6 and the hearsay statement of HCA 2. It considered that there is no other evidence to support this charge.

The panel had regard to Mr 6's NMC written statement, in particular: *"Some of the residents were neglected in terms of their personal care. We had a gentleman who used a urine bottle. He would often miss and in the event that he became wet, you would find that he would have changed himself as there were no staff to help him. He was impatient waiting for help".*

While the panel considered that patient hygiene was undoubtedly a part of fundamental care, it noted that the charge refers to an ‘unknown patient’. In his NMC written statement, Mr 6 did not identify the patient he referred to or provide details of dates. The panel also considered that the evidence of Mr 6 lacked clarity in relation to whether or not the unknown patient was required to be changed by carers, as the evidence indicated that the unknown patient was capable of changing himself.

It is for the NMC to prove this charge on the balance of probabilities, and the panel determined that the NMC had not discharged this burden. Given that the panel could not identify whether or not there was an issue with the unknown patient changing himself after covering himself in urine, the panel was not satisfied that Mrs Kale did not ensure that fundamental care was provided to the unknown patient. The panel therefore finds this charge not proved.

d) Residents were not showered or bathed regularly enough.

This charge is found NOT proved.

In reaching this decision, the panel considered the evidence of Mr 6 and noted that there was no other evidence to support this charge.

In his NMC written statement, Mr 6 makes reference to there being “no bathing rota” within the Home. He stated: *“But there were not enough bathing arrangements put in place and staffing was an issue. In the morning you would have two carers, one caring for the residents and one in the kitchen. With only one person on the floor you don’t have the time to do the bathing”.*

The panel reminded itself of its earlier findings in relation to there being insufficient staffing levels within the Home. However, the panel has not identified specific examples of times where patients were not bathed for any particular reason across any particular time. Given the absence of examples to indicate frequency of bathing, for particular

patients and their particular bathing needs, the panel did not consider it was in a position to quantify, objectively, what would qualify as “regularly enough”. It noted that there is no supporting evidence to substantiate Mr 6’s account.

The panel also had regard to a contemporaneous email, dated 25 March 2016, from a Contracts and Compliance Officer (CCO) at North Somerset Council which appeared to contradict the evidence of Mr 6 and, which reads:

> *“Bed changing and bathing/showering: No issues with this, evidence seen and two residents confirmed is ok”.*

It is for the NMC to prove this charge on the balance of probabilities, and the panel determined that the NMC had not discharged this burden. Given that this charge is non-specific, and given that the panel have identified an email indicating that there were ‘no issues’ in relation to bathing and showering of patients, the panel considered that there was insufficient evidence to find this charge proved.

Accordingly, the panel finds this charge not proved.

e) Residents’ nutritional needs were not adequately met.

This charge is found proved.

In reaching this decision, the panel considered Ms 5’s NMC written statement, specifically*: “We observed food service users were offered [sic] appeared poor quality. There was no evidence of any adaptations to service user’s needs…Our expectation is that we get good feedback from service users about the food. The regulations should be followed and there is one specific regulation around food, Regulation 14 ‘Meeting nutritional and hydration needs”.*

The panel considered that Ms 5 gave cogent evidence in relation patients' nutritional needs not being adequately met. She remained consistent about this during her oral evidence. The panel accepted Ms 5's evidence.

The panel further considered the contents of the CQC report, noting that Ms 5 had said that its contents had been quality assured to ensure findings were supported by evidence. It noted specifically: *"We found people's nutritional needs were not always assessed so people were at risk of receiving a diet which did not meet their needs and wishes…For example, one person required a low sugar diet due to their medical condition. During the inspection they were given the same food as everyone else including jam and rice pudding without adjustments to ensure the sugar level was reduced".*

The panel also noted the contents of an email, dated 24 May 2016, from Ms 3. The email reads:

> *"She [Patient 4] also said that she waits all day for food and the food isn't very nice…I was also worried as she seemed very thin and was complains [sic] of a lack of food".*

The panel also considered Mr 6's oral evidence. While the panel was aware of its earlier assessment of Mr 6's credibility and reliability as a witness, it noted that other witnesses which the panel found to be credible and reliable supported Mr 6's account. For these reasons, the panel was satisfied that it could rely on Mr 6's evidence on this point.

In his NMC written statement, Mr 6 states the following*: "…on the mid-afternoon tea rounds the residents were taking five, six, seven biscuits each which, to me, was beyond the norm. It gave me the sense they were not getting enough to eat. Some of the residents did complain that they were hungry, and would always accept seconds when offered".*

The panel considered all of the evidence before it. There are a number of sources of evidence to support the charge that specific nutritional needs were not being met. For example, all patients, including diabetic patients, were being placed on the same diet without consideration of their different nutritional needs and wishes. The panel also had regard to its earlier findings that there were a number of patients or whom the mandatory nutritional risk assessments had not been completed or updated. In light of this, the panel considered that on the balance of probabilities, it is more likely than not that Mrs Kale did not ensure that patients' nutritional needs were adequately met and thus did not ensure fundamental care in relation to nutrition.

Accordingly, the panel finds this charge proved.

Charge 19:

> 19) Did not ensure that staff at the Home were adequately trained in that one or more carers were not adequately trained in one or more of the areas set out in Schedule 3.

This charge is found proved.

In reaching this decision, the panel considered all the evidence and in particular that of Ms 1.

The panel took into account Ms 1's NMC written statement, specifically: *"As recorded in my clinical notes, I spoke to two carers 'B' and 'L' about their induction and training… Although 'B' reported having been taught about Mental Capacity Assessments and Deprivation of Liberty Safeguards, she was clearly unsure what they were for by the statement she made that the only resident not requiring a DoLS was CO in room 14…I noted what 'L' told me had been covered in the training within my clinical notes. She reported most of it was video and discussion. She did not refer to online training. She reported most of it being video - the only practical component being manual handling.*

Her medications training in house was non-existent. Neither 'B' or 'L' had any blood sugar monitoring training".

The panel was satisfied that the staff discussions undertaken by Ms 1, particularly with carers 'B' and 'L', demonstrated that carer 'B' lacked adequate training in Mental Capacity Assessments/Deprivation of Liberty Safeguards, carer 'L' lacked adequate training in medications administration, and both lacked adequate training in blood sugar monitoring, three of the areas of training set out in Schedule 3. The panel considered that Ms 1 was a reliable witness with a clear knowledge of teaching and the standard of training she would expect all care staff to have in a care home setting. She identified the NMC Code of Conduct as relevant in terms of delegating tasks and and duties to other people and ensuring others perform the tasks to the required standards. The panel was satisfied that Mrs Kale had a duty to ensure that staff were adequately trained. The panel accepted Ms 1's evidence and was satisfied that Mrs Kale did not ensure that staff were adequately trained in one or more of the areas set out in Schedule 3. Accordingly, it finds this charge proved.

Charge 20:

20) Did not ensure that there was an adequate recruitment process place in that:

a) HCA1 commenced employment at the Home prior to a Disclosure and Barring Service check being completed.

This charge is found NOT proved.

In reaching this decision, the panel considered the evidence of Ms 5 and Mr 6 and noted that there was no other evidence to support this charge. The panel identified Mr 6 as HCA 1.

The panel noted Mr 6's NMC written statement, specifically: *"Employers normally wait for a DBS check to come through before new staff start. However, they told me I would be starting off by doing paperwork and office-based duties, budgeting and spending etc. I had to deal with the shopping and bills and what not. That very quickly turned into not being the case. I also provided care to residents. I was told that an electronic version of my DBS check had already been received".*

Given the panel's assessment of Mr 6's credibility and reliability, it approached his evidence with a degree of caution. Further, it identified discrepancies between his written and oral evidence regarding aspects of how he came to take up his employment. Given that he is the sole witness in relation to this charge, the panel sought to find supporting evidence before accepting Mr 6's account. It noted Ms 5's NMC written statement, specifically: *"Some staff had no Disclosure and Barring Service (DBS) checks on their files. Others had incomplete references and one had no label to identify who the file was for".* However, Ms 5 had not identified Mr 6, HCA 1, as being such a member of staff.

Whilst Ms 5, within her CQC report, says: *"One staff member told us they had started working prior to having their DBS check completed"*, the panel noted that Mr 6 was likely to have been the source of this information. The panel did not consider that this was independent supporting evidence for Mr 6's evidence.

While the panel acknowledged that Ms 5 describes the circumstances in which Mr 6 commenced employment with the Home, it has seen evidence to suggest that there was a second staff member who had not had the correct DBS check completed. The panel considered that the evidence of Ms 5 in relation to this charge is too non-specific, in that it does not confirm whether HCA 1 commenced employment at the Home prior to a Disclosure and Barring Service check being completed.

Given the panel's concerns regarding the veracity and discrepancies in Mr 6's evidence and that there is insufficient independent supporting evidence to substantiate his account, accordingly the panel finds this charge not proved.

b) References were obtained from previous employers who had not been declared in the staff member's application form.

This charge is found proved.

In reaching this decision, the panel considered Ms 5's NMC written statement, specifically: *"looked through the staff files and they also were a mess. Many of the references were incomplete."*

She goes on to say: *"My concerns were around…references being obtained from previous employers who had not been declared in the staff member's application form…".*

The panel further noted the contents of the CQC report, specifically: *"The provider and registered manager had no completed pre-employment checks which included checking previous employment gaps or gaps in employment. For example, one member of staff had a period of six months without employment; there were no checks by the provider to cover this period".*

The panel accepted the evidence of Ms 5 who remained consistent when questioned during her oral evidence. The panel was satisfied that references were obtained from previous employers who had not been declared in the staff members application form. Accordingly, the panel determined that there was sufficient evidence to satisfy it, on the balance of probabilities, that Mrs Kale did not ensure that there was an adequate recruitment process in place at the Home.

C) Gaps in employment of staff members were not checked.

This charge is found proved.

In reaching this decision, the panel considered Ms 5's NMC written statement, specifically: *"My concerns were around gaps in employment of staff members not having been checked…"*

The panel also had regard to the Statement of Reasons document provided to the Magistrates Court on 27 May 2016, identifying concerns regarding references. It said: *"some references were hand written on rough pieces of paper and there were gaps in people's employment history…some staff did not have a references from their last known employer".* The panel noted that the Statement of Reasons was prepared for court proceedings to cancel the registration of Mrs Kale's husband as Registered Provider, but the information within it was based on the evidence gathered and collected by Ms 5 doing the CQC inspection of the Home.

The panel accepted the evidence of Ms 5 who remained consistent when questioned during her oral evidence. The panel was satisfied that gaps in employment of staff members were not checked. Accordingly, the panel was satisfied that there is sufficient evidence to satisfy it, on the balance of probabilities, that Mrs Kale did not ensure that there was an adequate recruitment process in place at the Home.

d) One or more carers did not receive a proper induction to the Home.

This charge is found proved.

In reaching this decision, the panel considered Mr 6's NMC written statement, specifically: *"I did not get an induction when I started at the home".* As before, the panel approached Mr 6's evidence with a degree of caution. The panel sought to find supporting evidence before accepting Mr 6's account.

The panel noted the email, dated 5 May 2016 from a carer at the Home, who was reporting her concerns to Ms 3 as referenced in Ms 3's NMC written statement. The email reports: *"At 8:15pm I phoned Sharmila and said that the wake staff haven't turned up and she said that she would ring around and cover the shift. I had a phone call back saying that a girl called KC would do the wake shift…We went in the kitchen and she discussed with myself and KF that she applied for a carers job on Indeed.com. She had never been in the building before, no CRB had been done. As far as I am aware she had not met Sharmila. She said because she hadn't been [sic] the building before she didn't know the residents and routine and felt uncomfortable being there".*

The panel considered that this email was evidence to demonstrate a carer due to undertake a shift, without having been given a proper induction to the Home. The panel considered that this evidence was supportive of the account of Mr 6 that he was no given an induction when he started at the Home, and that it could rely on the evidence of Mr 6 on this point. The panel was satisfied that two carers did not receive a proper induction to the Home. Accordingly, the panel determined that there is sufficient evidence to satisfy it that Mrs Kale did not ensure that there was an adequate recruitment process in place at the Home.

Charge 21:

21) Did not ensure that equipment was maintained and/or audited safely in that quality control assessments for glucometer devices were not audited and/or recorded.

This charge is found proved.

In reaching this decision, the panel considered the NMC written statement of Ms 1, specifically*: "There was no policy regarding the use of or QCA (Quality Control Assurance) process for this device (glucometer) within the home. There was no record, protocol, standard operating procedure ("SOP") for undertaking either QCA testing or*

*capillary blood glucose testing. The registrant should have created the relevant policy or SOP, created auditable records of QCA of the device and, if delegating the task (when she was not there) to more junior members of staff, there should have been clear training records, aims, objectives, and equitable non-subjective clear assessment tools for those she had trained and assessed as competent to undertake this skill in terms both of practical competency and knowledge for safe, best practice. I asked the registrant how she had checked that the device was functioning properly. Her test, in her words, had been that '*the device turned on with no error messages.*'".*

The panel considered Ms 1's knowledge of auditing of blood glucose testing devices within care homes to be extensive. She was able to provide a detailed explanation of how glucometer devices function and their purpose. As such, the panel was satisfied that it could rely on her evidence. The panel was satisfied that Mrs Kale did not ensure that equipment was maintained and/or audited safely in that quality control assessments for glucometer devices were not audited and/or recorded.

Accordingly, the panel finds this charge proved.

Charge 22:

22) Did not ensure that a safe environment was maintained in the Home in that:

a) One or more residents who were at risk of falls were placed in rooms which opened onto a landing with stairs with no gate.

This charge is found proved.

In reaching this decision, the panel considered Ms 1's NMC written statement, specifically: "*In my clinical notes I recorded,* 'There was a further safety concern, the lady in room 10 and the gentleman in room 15, one was very confused, distressed on several occasions whilst we were there and the man in room 15 - history of falls. Their

rooms opened onto landing and straight onto stairs but there was also an area at the top of the stairs that they could lean over and fall down. When raised with the manager she could not understand the concerns.'"

The panel identified the lady in room 10 to be Patient 7, who was recorded in the patient notes as at risk of falls. The panel considered that Ms 1 had a good recall of Patient 7, and remained consistent about what she had witnessed during her oral evidence. Ms 1 told the panel that she saw Patient 7 'wandering' and appeared to be 'agitated' and 'confused'. The panel accepted Ms 1's account. The panel was satisfied, on the balance of probabilities, that Mrs Kale did not ensure that a safe environment was maintained in the Home in that at least one patient who was at risk of falls was placed in a room which opened onto a landing with stairs with no gate.

Accordingly, the panel finds this charge proved.

b) The Home was not compliant with fire safety regulations.

This charge is found proved.

In reaching this decision, the panel had regard to the contents of a letter, dated 24 May 2016, from Avon Fire & Rescue Service ("the Fire Service"), following an inspection of the Home on the same date. Ms 5 had liaised with the Fire Service during her CQC inspection and raised concerns with them about compliance with fire safety regulations at the Home. As a consequence, the Fire Service visited the Home on 24 May 2016 and conducted a fire safety audit, the results of which were set out in the letter dated 24 May 2016. The letter reports their findings in relation to insufficient fire safety arrangements, firefighting measures, evacuation procedures and safety drills. The letter proposes an 'Action Plan' to ensure compliance with the Regulatory Reform (Fire Safety) Order 2005.

The panel also had regard to Ms 5's NMC written statement, which informed the CQC report. In her written statement, she reports: *"In addition to the issue of door being propped open by a chair, we also found a garden gnome propping open a fire door".*

The panel considered that there was a formal request made by Avon Fire & Rescue Service to take action due to the Home being non-compliant with fire safety regulations. The panel was satisfied that the Home had not complied with fire safety arrangements, and the findings were set out in the letter of 24 May 2016. Accordingly, the panel was satisfied that Mrs Kale did not ensure that a safe environment was maintained in the Home, in that the Home was non-compliant with fire safety regulations.

c) There was no adequate cleaning rota in place at the Home.

This charge is found proved.

In reaching this decision, the panel considered Mr 6's NMC written statement, specifically: *"There was no designated cook or cleaner so you had to be a jack of all trades – cooking, cleaning, caring, medication. There was no one set task for anybody. Everybody did everything".*

He then states: *"It was standard practice and normal to include deep cleans in the rotas but this was not the case at Wyvern Lodge".*

As before, the panel approached Mr 6's evidence with a degree of caution. The panel sought to find supporting evidence before accepting Mr 6's account.

The panel noted the contents of the CQC report, specifically: *"During this inspection, staff were wearing gloves and aprons when completing personal care to reduce infections spreading. However, people were at risk of infections spreading because the home was not being regularly deep cleaned. No member of staff was employed*

specifically as a cleaner. Unless a staff member was named on the rota the care staff were expected to undertake the cleaning."

The panel considered that the CQC report independently supported the evidence of Mr 6 on this point, and so it was able to accept his evidence on it.

The panel also had sight of staffing rotas for April 2016. On a number of dates, the notes showed no specific individual allocated to cleaning within the Home, but rather care staff were allocated on a shared basis. The panel had regard to its earlier findings in relation to sufficient staffing levels, in that, a minimum of three carers during the day was required. On days were the rotas recorded that no member of staff was allocated to cleaning and only three members of staff in total were on duty, the panel considered that the cleaning rotas were inadequate. For example, the panel noted the contents of the rota for 11 April to 17 April. It noted that on 16 and 17 April, which was a weekend, there was no cleaner allocated and only three members of staff in total on duty.

The panel considers at least daily cleaning to be adequate given the needs of patients. On the basis that there was no allocated cleaner within the Home, that a cleaner was not always allocated on the rota, and at least three members of staff were required to provide patient care, the panel was satisfied that there was an unreliable cleaning system in place within the Home.

The panel is satisfied that Mrs Kale did not ensure that a safe environment was maintained in the Home, in that there was no adequate cleaning rota in place at the Home.

Accordingly, the panel finds this charge proved.

d) Dishes were not cleaned adequately.

This charge is found NOT proved.

In reaching this decision, the panel considered Mr 6's evidence and noted that there was no other evidence to support this charge.

The panel had regard to Mr 6's NMC written statement, specifically: *"The kitchen in the home was a difficult place to keep clean. I know that one of the Environmental Health issues was that the dishwasher was not being used. We were handwashing instead and not using sterilising solutions to make sure the plates were absolutely clean. Staff at the Environmental Health inspection were told the machine was broken and not to be used but Environmental Health said it was fine and we should use it".*

As before, the panel approached Mr 6's evidence with a degree of caution. The panel sought to find supporting evidence before accepting Mr 6's account. While Mr 6 makes reference to the Home's faulty dishwasher, the panel found no supporting evidence to substantiate his account.

The panel saw no evidence from Environmental Health specifically relating to the standard expected for maintaining an adequate cleaning of dishes, in particular that they were required to be cleaned with a dishwasher, or if hand washed, that sterilising solutions were required. Nor did it see evidence to support whether or not there was a concern about the faulty dishwasher or indeed the standard of cleaning dishes.

It is for the NMC to prove this charge on the balance of probabilities, and the panel determined that the NMC had not discharged this burden.

The panel therefore finds this charge not proved.

Charge 23:

23) On 27 May 2016 left your post at the Home without first arranging adequate cover to maintain the safety of the residents.

This charge is found proved.

In reaching this decision, the panel considered the Statement of Reasons, specifically: *"On 27 May 2016 an email was received from [Mrs Kale's husband, the Registered Provider], stating that despite his best efforts he was no longer able to provide the service for Wyvern Lodge".*

Further, the panel considered the NMC written statement of Ms 3, specifically: *""The husband of the registrant phoned me on morning of Friday 27 May 2016, he said he was at the airport with his wife, The husband said to me "they were leaving, that they were no longer at Wyvern Lodge and that we had better get over there". At this point we were unsure if that meant there were any staff supporting the people who lived there or enough staff on duty to do that safely. We asked another organisation to step in to oversee the safe closure of that service.""* Following this call, Ms 3 said that she had gone to the Home.

The panel was of the view that Ms 3 remained consistent about this during her oral evidence. Ms 3 informed the panel that there were two carers present at the Home when she arrived. When questioned as to whether she would consider two carers, in her professional opinion, to be adequate cover, Ms 3 stated that she would not consider this to be adequate cover for 11 patients within the Home. The panel also had regard to its earlier findings that a minimum of three carers was required during the day to ensure adequate staffing cover.

The panel further heard evidence from Mr 6 that Mrs Kale was 'uncontactable' in the days leading up to 27 May. While the panel had concerns regarding Mr 6's veracity and

discrepancies in his evidence, it noted that other witnesses which the panel found to be credible and reliable supported Mr 6's account. In particular, Ms 5 said that the last time she had seen Mrs Kale was on 23 May 2016, the third day of the CQC inspection. She returned to the Home on 26 May 2016 to finish giving verbal and written feedback to Mrs Kale. *"However, she was not present and staff were unable to say where she was, or when she would return".* For these reasons, the panel was satisfied that it could rely on Mr 6's evidence in its consideration of this charge.

Taking all of the above into account, the panel was satisfied that there was sufficient evidence to support this charge. It was satisfied that Mrs Kale had left the Home on 27 May 2016. As the only Registered Nurse and the Registered Manager of the Home, the panel considers that the two carers at the Home were left without support or provision of information with regards to fundamental aspects of patient care, placing patients at risk and compromising their safety. The panel had regard to the actions of the CQC and the Council following discovery that Mrs Kale was no longer at the Home. Ms 3 said that the Council arranged for a manager to go in and *"oversee the safe running of the care home until we could safely move people to other placements".* The CQC made an application to the Magistrates Court that day, for the closure of the Home.

Given that it was determined by the CQC that the welfare of the patients using the service was compromised as a result of Mrs Kale leaving her post at the Home on 27 May 2016 without first arranging adequate cover, she did not maintain the safety of the residents.

Accordingly, the panel finds this charge proved.

Submissions on misconduct and impairment

Having announced its findings on all the facts, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mrs Kale's fitness to practise is currently impaired by reason of it. 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 NMC Register unrestricted.

The panel noted its duty to protect patients, to maintain public confidence in the profession and in the regulatory process, and to declare and uphold proper standards of conduct and behaviour.

Mr Edwards referred the panel to the cases of *Calhaem v General Medical Council* [2007] EWHC 2006 (Admin), *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Roylance v General Medical Council* [2000] 1 AC 311 (Admin) in which Lord Clyde defined misconduct *"as a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the [relevant field]. Such falling short as is established should be serious."*

Mr Edwards submitted that this case engages both public protection and public interest considerations. He submitted that the charges found proved are serious, and demonstrate wide-ranging concerns in relation to the fundamental care of patients. Mr Edwards reminded the panel that this case also involves an element of dishonesty and submitted that honesty and integrity is at the bedrock of the nursing profession.

Mr Edwards invited the panel to take the view that Mrs Kale's actions amount to a breach of 'The Code: Professional standards of practice and behaviour for nurses and

midwives (2015)', (the Code). He then invited the panel's attention to specific paragraphs and identified where, in the NMC's view, Mrs Kale's actions amounted to misconduct.

Mr Edwards then 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. He referred the panel to the cases of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). He submitted that this case involves all four limbs of the *Grant* test.

Mr Edwards referred the panel to a written response from Mrs Kale, received by the NMC on 22 September 2017, and submitted that it is demonstrable of a "complete lack of insight" into her misconduct. He added that her response demonstrates a lack of understanding, remorse or acceptance of her roles and responsibilities as a Registered Nurse and as the Registered Manager of the Home.

Mr Edwards submitted that Mrs Kale's failings placed particularly vulnerable patients under her care at risk of harm. He further submitted that Mrs Kale has subsequently failed to recognise the impact of her actions on patients at the Home. Mr Edwards invited the panel to consider whether Mrs Kale's actions could be attributed to an underlying attitudinal issue. Mr Edwards submitted that Mrs Kale had brought the reputation of the nursing profession into disrepute and breached fundamental tenets of the nursing profession.

Mr Edwards submitted that in light of the above, a finding of impairment is necessary on both public protection and public interest grounds in order to uphold proper professional standards and uphold public confidence in the NMC as a regulator.

The panel accepted the advice of the legal assessor, who emphasised that there is no burden of proof at this stage and the decision on misconduct is for the panel's

independent judgement. She referred the panel to the case of *Roylance v General Medical Council* [2000] 1 AC 311. *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *R (Bevan) v General Medical Council* [2005] EWHC 174 (Admin).

The panel first adopted a two-stage process in its consideration, as advised. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Kale's fitness to practise is currently impaired as a result of that misconduct. The panel, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage and exercised its own professional judgement.

Decision on misconduct

In considering whether the conduct found proved amounted to misconduct, the panel was aware that not every act falling short of what would be proper in the circumstances, and not every breach of the Code, would be sufficiently serious that it could properly be described as misconduct.

The panel considered that the charges found proved occurred over a prolonged period of time, involved multiple patients, who were particularly vulnerable and for whom Mrs Kale had explicit responsibility for their care, wellbeing and safety. In the panel's view, the charges found proved were representative of failures which were serious and wide-ranging. Given the large number of charges found proved, the panel adopted the approach of identifying the specific areas in which Mrs Kale's actions and omissions had fallen short of the standards to be expected of both a Registered Nurse and a Registered Manager.

In relation to charges one to 10, Mrs Kale did not ensure appropriate care for multiple patients in the Home. As the Registered Manager, who was also a Registered Nurse, she did not organise or take responsibility for implementing appropriate systems in

order to ensure the safety, wellbeing and appropriate care for patients. There was no system to ensure that comprehensive care plans were established, reviewed and documented, or that mandatory risk assessments were carried out and documented. The impact of this would be that carers would not easily be able to ascertain the care provision and dependency of individual patients. Therefore, the impact of this was that there was a risk that patient's individual needs and the specific care required would not be provided safely by all members of staff.

In the panel's judgement, there was also a lack of a patient centred approach, with no proper systems of governance in place for ensuring appropriate patient consents were obtained; DoL's applications were made; investigations for unexplained bruising/injuries were carried out; appropriate safeguarding referrals were made in respect of patients at risk of, for example, physical or financial abuse. These failures all had significant potential consequences for patient safety.

In relation to charge 5d, 7d, 8d, 11 and 14, the panel was of the view that Mrs Kale had not ensured that there were safe systems in place in respect of medicines management. The consequences of this were that MAR charts were not double signed where required, documenting of disposal of drugs was not accurate and the 'checking in' of medication delivered by the pharmacy was not carried out, leaving medication unsecure, with the consequence that anyone visiting or patients at the Home may access patient medication.

In relation to charge 18, Mrs Kale did not have systems in place to ensure that fundamental care was consistently provided to patients such as for a patient with particularly dependent mobility issues being able to call for assistance as well as meeting patients' nutritional needs. The impact of this was that there was a significant risk of harm to patients' health and safety.

In relation to charges 13, 19 and 20b-d, Mrs Kale did not ensure that there were effective systems in place in respect of staffing. Consequently there were, in the panel's

view, a number of workforce issues, the evidence indicated that there was a high turnover of staff. There was no adequate recruitment process for new staff, with references not being properly obtained; gaps in employment not checked; and a lack of a proper induction process for newly recruited staff. Sufficient staffing levels were not maintained. The consequences of this were that there was a high risk that unsuitable people may be employed without the necessary checks, nor having undertaken appropriate inductions, all of which placed patients at a significant risk of harm.

Within the Home, Mrs Kale did not ensure that the staffing levels were sufficient. There were multiple occasions when there were fewer members of staff (carers) on duty than the minimum number of three carers during the day and two carers during the night. Given the absence of Barthel risk assessments, the panel considered that Mrs Kale had not implemented effective systems to ensure that staffing levels were appropriate according to patient dependency needs, for example for patients with mobility needs who required two carers to assist them. Consequently, this placed patients at a significant risk of harm, due to not having their specific needs met or care provided.

In relation to charges 16, 17 and 19, the panel was of the view that Mrs Kale did not have systems in place to ensure that members of staff were adequately trained, which meant that they were at risk of lacking the skills and knowledge to care for patients. It was apparent that carers' skills and knowledge was lacking in areas of fundamental care, such as blood sugar monitoring, medications administration and mental capacity assessments.

Mrs Kale, in the panel's view, also had a disregard for the importance of her own training, not completing the mandatory training provided by outside trainers. The panel considered that the lack of adequate training for both herself and members of staff had significant implications for patient safety.

In relation to charge 23, the panel was of the view that, following an adverse inspection, Mrs Kale, together with her husband, the Registered Provider, decided to leave the

Home without arranging adequate cover. Two carers were at the Home when Ms 3 arrived on 27 May 2016. This meant that the Home was understaffed, but also patients being cared for by carers who potentially had not been appropriately recruited or adequately trained. In the panel's judgement, Mrs Kale had left the Home without ensuring that there were systems in place to safeguard and care for multiple patients with different needs. The panel considered that this was tantamount to "abandoning" the Home, and leaving it to the Council and the CQC to take measures to protect the patients. In the panel's view, this placed patients at significant risk of severe harm.

As a Registered Nurse and the Registered Manager of the Home, the panel was satisfied that an ordinary member of the public would expect Mrs Kale to have effective management of all areas of practice within the Home. However, she failed to ensure safe and effective delivery of care to patients. It considered from both a professional and a legal point of view, that Mrs Kale's acts and omissions would be considered deplorable by a fellow Registered Nurse and an informed member of the public.

The panel had regard to any potential attitudinal issues. Concerns about the Home and specifically Mrs Kale's failings had been raised with her by the Council and the CQC inspectors. However, Mrs Kale, in the panel's judgement, demonstrated an inability to take on board constructive feedback from colleagues and professional bodies and did not use such feedback to improve aspects of the Home in any meaningful way. On the contrary, the panel considered she was dismissive or unaware of her duties and responsibilities as a Registered Nurse and the Registered Manager. Further, Mrs Kale acted dishonestly by providing a CQC inspector with a certificate for training which she knew she did not complete. This in itself had consequences for patient safety, as Mrs Kale was intending to deceive the CQC Inspector into accepting that Mrs Kale had been certified as competent in the areas of mandatory training when she had not been. She also left her post at the Home without first arranging adequate cover to maintain the safety of patients. Both of these actions appeared to be deliberate and premeditated. The panel considered that this would be considered deplorable by a fellow Registered Nurse and an informed member of the public.

The panel bore in mind that registrants are personally accountable under the NMC Code for acts and omissions in their practice. The panel had regard to the relevant version of the NMC Code (2015) and determined that Mrs Kale's conduct had breached the following areas of the Code:

Prioritise people

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

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered…

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

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

5 Respect people's right to privacy and confidentiality

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

<u>Practise effectively</u>

8 Work co-operatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

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

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

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

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

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

Preserve safety

Preamble: You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

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

To achieve this, you must:

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

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

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

To achieve this, you must:

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

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

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

<u>Promote professionalism and trust</u>

<u>Preamble:</u> You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times…

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

To achieve this, you must:

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

The panel found that Mrs Kale's actions fell far below the conduct and standards expected of a Registered Nurse and undoubtedly amounted to misconduct. The panel was of the view that Mrs Kale's acts and omissions formed a pattern of serious failings in a clinical setting alongside those relating to her attitude and lack of acceptance of those failings which placed particularly vulnerable patients at a significant risk of harm and which brought the nursing profession into disrepute.

Decision on impairment

The panel next went on to decide if as a result of this misconduct, Mrs Kale's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must…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 judgement of Mrs Justice Cox in the case of *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.

Mrs Justice Cox went on to identify the following test to assist panels in determining whether a registrants fitness to practise is impaired, Paragraph 76:

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

The panel finds that all limbs are engaged in this case. In particular, patients at the Home had clearly been placed at unwarranted risk of harm, given the wide-ranging failures in respect of Mrs Kale's management of the Home.

The panel considered whether Mrs Kale has demonstrated any insight and/or remorse into her misconduct. It took into account Mrs Kale's written response, received by the NMC on 22 September 2017, and considered that there has been no other meaningful engagement with the NMC from Mrs Kale since. The panel considers that Mrs Kale's

response demonstrates a complete lack of insight and remorse into her failings. It appears that Mrs Kale seeks to blame others for her failings, including the Home's previous manager, her regulator and other professional bodies. The panel was of the view that Mrs Kale's written response demonstrates a 'total denial' of her roles and responsibilities as a Registered Nurse and as the Registered Manager of the Home.

In order to assess whether Mrs Kale would put patients at risk of harm in the future, the panel first considered whether Mrs Kale's failings are remediable and, if so, to what extent Mrs Kale has remedied her misconduct.

In determining whether Mrs Kale's failings are remediable the panel considered that, taken individually, many of the concerns identified in her practice are potentially remediable. However, given Mrs Kale's total lack of insight, demonstrated in her response, and her attitudinal issues, the panel questioned whether Mrs Kale would be capable of identifying what was required on her part in order to remedy her failings. In any event, it noted that there has been no meaningful engagement from Mrs Kale since 2017, and that her earlier responses with her regulator are indicative of a complete disregard of her duties as a Registered Nurse and the Registered Manager of the Home. The panel has seen no information to satisfy it that Mrs Kale has remediated any of the concerns identified to date or taken any steps to attempt to do so. In the absence of any recent information, the panel was not satisfied that Mrs Kale has made any attempts to remediate her misconduct.

The panel therefore concluded that the risk of repetition remained high in that if Mrs Kale were placed in a similar situation, she could in the future act so as to put patients at unwarranted risk of harm, breach the fundamental tenets of the profession and bring the profession into disrepute and act dishonestly. Accordingly, a finding of impairment on the grounds of public protection is necessary.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and wellbeing of the public and patients, and to

uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. The panel determined that, in this case, a finding of impairment on public interest grounds was also required. It was of the view that a member of the public would be concerned if impairment was not found on this ground in view of the panel's findings relating to wide-ranging concerns, involving both Mrs Kale's clinical and managerial role within the Home.

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

Determination on sanction

After careful consideration the panel decided that it was appropriate and proportionate to make a striking-off order. The effect of this order is that the NMC register will show that Mrs Kale has been struck-off the register.

Mr Edwards on behalf of the NMC addressed the panel on what the NMC considered were aggravating and mitigating features of Mrs Kale's case and made submissions in relation to the approach the panel should take at the sanction stage. He invited the panel to have regard to the SG. Mr Edwards submitted that in the light of the panel's findings, the NMC's sanction bid was that of a striking-off order. He submitted that the charges found proved are so serious as to warrant removal from the NMC Register. However, he accepted that this is overall a matter for the panel's professional judgement. He referred the panel to the case of *Parkinson v NMC [2010]* EWHC 1898 (Admin), where Mr Justice Mitting said:

> *"A nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. A nurse who has acted dishonestly, who does not appear before the Panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct*

criticised was dishonest, and an undertaking that there will be no repetition, effectively forfeits the small chance of persuading the Panel to adopt a lenient or merciful outcome and to suspend for a period rather than direct erasure."

He also referred the panel to the case of *Atkinson v General Medical Council* [2009], in which Mr Justice Blake stated that:

'…erasure is not necessarily inevitable and necessary in every case where dishonest conduct by a medical practitioner has been substantiated. There are cases where the panel, or indeed this court on appeal, have concluded in the light of the particular element that a lesser sanction may suffice…. bearing in mind the important balance of the interest of the profession and the interest of the individual. It is likely that for such a course to be taken, a panel would normally require compelling evidence of insight and a number of other factors upon which it could rely that the dishonesty in question appeared to be out of character or somewhat isolated in its duration or range, and accordingly there was the prospect of the individual returning to practice without the reputation of the profession being disproportionately damaged for those reasons.'

Mr Edwards submitted that given the risk of repetition in this case, taking no further action would be inappropriate. He also submitted that a caution order would be inappropriate, as this would not restrict Mrs Kale's practice.

Mr Edwards submitted that a conditions of practice order would also not be appropriate, workable or practicable, given that the facts found proved in this case cover a wide-range of concerns, which are not limited to a specific area of practice, such as medications management, which might be able to be remedied by a conditions of practice order. He also reminded the panel that this case involves an element of dishonesty, which the panel may consider difficult to remediate through conditions of practice. Further, he submitted that given that Mrs Kale has not engaged with her regulator in any meaningful way since 2017, in any event, conditions of practice would not be workable.

Mr Edwards submitted that a suspension order would not be sufficient given that the panel found the dishonesty to be deliberate, premeditated and involved a risk to patient safety. He also submitted that the panel found that there is evidence of a deep seated attitudinal issue and a risk of repetition in this case.

In reaching its decision on sanction, the panel has had regard to all the evidence adduced both orally and in writing and to its earlier findings at the facts and impairment stages. The panel accepted the advice of the legal assessor, who referred the panel to the cases *of Igboaka v General Medical Council* [2016] EWHC 2728 (Admin) and *Lusinga v Nursing and Midwifery Council* [2017] EWHC 1458 (Admin). 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 Sanctions Guidance (SG) published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel first considered what it deemed to be the aggravating and mitigating factors in this case and determined the following:

Aggravating factors:

- there is no evidence of remediation;
- Mrs Kale's written representations are indicative of a total lack of insight, coupled with no real understanding of the seriousness of the charges or indeed the serious failings in how the Home was managed and the risk Mrs Kale placed particularly vulnerable patients under her care in;
- there is no evidence of remorse;
- there has been no meaningful engagement from Mrs Kale in these proceedings;
- the facts found proved cover wide-ranging concerns across all areas of care and management of a care home;

- the incidents span a substantial period of time, between November 2015 and May 2016;
- there is evidence of a poor attitude in response to concerns raise by others, including the Council and the CQC;
- Mrs Kale 'abandoned' the Home on 27 May 2016 without adequate cover, exposing patients to a significant risk of harm;
- Mrs Kale was the only Registered Nurse within the Home, and so the Home was left without a Registered Nurse when she left;
- this case involves dishonesty.

Mitigating factors:

- there have been no previous regulatory concerns in relation to Mrs Kale's practice.

The panel has applied the principles of fairness, reasonableness and proportionality to the particular circumstances of this case. It has carefully weighed the public interest with Mrs Kale's own interests and taken into account the mitigating and aggravating factors of the case.

Under Article 29 of the Nursing and Midwifery Council Order 2001 the panel can take the following actions in ascending order: no action; a caution order for between one to five years; a conditions of practice order; a suspension order for a maximum of one year or a striking off order.

With this in mind, the panel went onto consider what action, if any, to take in this case.

The panel first considered whether to take no action but concluded that given the serious nature of the misconduct and the high risk of repetition identified by the panel, this would be wholly inappropriate. To take no further action would not restrict Mrs Kale's practice and would therefore not serve to protect patients from the risk of harm arising from any repetition of her misconduct. In addition, the nature and seriousness of

the misconduct in this case were such that to take no further action would not serve to declare and uphold proper professional standards and maintain public confidence in the profession. To take no further action would therefore not satisfy the public interest considerations in this case.

For the same reasons, the panel concluded that a caution order would not be a sufficient or appropriate sanction.

The panel next considered whether to impose a conditions of practice order. It was mindful that any conditions imposed must be proportionate, measurable practicable and workable.

In the panel's judgement, the misconduct found is too wide-ranging for conditions of practice to be workable. The concerns identified cover all areas of nursing practice, which collectively cannot readily be addressed by a conditions of practice order. The panel concluded that workable conditions of practice could not be formulated which would be sufficient to protect the public. The panel also considered that a conditions of practice order would be insufficient to satisfy the public interest considerations in this case, particularly in the light of Mrs Kale's lack of engagement with her regulator, leading the panel to conclude that it had little confidence that Mrs Kale would be willing or able to remedy her failings.

The panel also considered that it would not be possible to formulate suitable, practicable and workable conditions which would address the dishonesty and the attitudinal concerns in this case.

The panel went on to consider whether to impose a suspension order. The panel had regard to the SG which states such an order may be appropriate in the following circumstances:

- *a single instance of misconduct but where a lesser sanction is not sufficient*

- *no evidence of harmful deep-seated personality or attitudinal problems*
- *the Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour*

The panel did not consider that this case involved a single instance of misconduct. There were repeated failings on Mrs Kale's part over a prolonged period of time, which involved multiple patients, who were particularly vulnerable, and for whom Mrs Kale had responsibility, as a Registered Nurse and the Registered Manager of the Home, in respect of their care, wellbeing and safety.

The panel considered that there was evidence of a deep seated attitudinal problem. This was not only in respect of the dishonesty found proved which, in the panel's judgement, was deliberate and premeditated, but also in relation to her inability to take on board constructive feedback and by her being dismissive or unaware of her duties and responsibilities as a Registered Nurse and the Registered Manager. She also left her post at the Home without first arranging adequate cover to maintain the safety of patients.

Furthermore, the panel was not satisfied that Mrs Kale had demonstrated any insight, remorse, understanding or acceptance into her misconduct. Rather, the evidence demonstrates that Mrs Kale sought to blame others for her failings. As earlier identified, the panel considered that there was a significant risk of her repeating her behaviour, which would expose patients to significant risk of harm.

The panel considered that Mrs Kale's actions were so serious, that they fell far below the standards expected of a Registered Nurse. The panel did not consider that, in the circumstances of this case, a period of suspension would be sufficient to protect patients, public confidence in nurses and to maintain professional standards.

Balancing all of these factors, the panel has determined that a suspension order would not be an appropriate or proportionate sanction.

The panel next considered whether to impose a striking-off order. In doing so, it had regard to the SG which states that key considerations the panel will take into account include:

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

It also had regard to the SG on cases involving dishonesty, published by the NMC.

The panel considered that Mrs Kale's acts and omissions raised fundamental questions about her professionalism. In particular, the panel noted that Mrs Kale deliberately intended to deceive a CQC inspector, did not ensure the safe and effective delivery of care to particularly vulnerable patients, and abandoned the Home without first arranging adequate staffing levels to ensure the care, safety and wellbeing of those patients. The panel was in no doubt that Mrs Kale's acts and omissions placed patients at a significant risk of harm.

The panel considered that Mrs Kale's misconduct in this case was so serious that members of the public would be extremely concerned if she was allowed to continue practising and remain on the NMC Register. It considered that public confidence in the nursing profession and in the NMC as a regulator could only be maintained if Mrs Kale was removed from the NMC Register permanently.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction in this case is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Mrs Kale's acts and omissions in bringing the profession into disrepute by adversely affecting the public's view of how a Registered

Nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case. The panel considered the seriousness of Mrs Kale's misconduct was fundamentally incompatible with being a Registered Nurse, and therefore a striking-off order was the only sanction that was sufficient to protect patients, members of the public and maintain professional standards.

In terms of the principle of proportionality, the panel was mindful that Mrs Kale would be prevented from working in the profession by this order, which may adversely impact her financially, although the panel has no up to date information in this regard. In any event, the panel was of the view that the need to protect patients, maintain public confidence, and uphold standards outweighed Mrs Kale's own personal interests.

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

The panel therefore concluded that a striking-off order was the only appropriate and proportionate sanction to reflect the seriousness of the case and maintain public confidence in the profession and in the NMC as a regulator.

Determination on Interim Order

The panel has considered the submissions made by Mr Edwards that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest. He invited the panel to impose an interim suspension order for 18 months.

The panel accepted the advice of the legal assessor.

The panel had regard to the seriousness of the facts found proved, and the reasons set out in its decision for the substantive order.

The panel decided that an interim suspension order is necessary for the protection of the public and it is otherwise in the public interest. For the same reasons as given in its substantive decision, the panel concluded that an interim conditions of practice order would be sufficient to protect the public or meet the public interest concerns. Any other conclusion would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.