Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Meeting

14 – 18 June 2021

Virtual Meeting

Name of registrant:	Mrs Joan Parr
NMC PIN:	72H1273E
Part(s) of the register:	RN1 – 1976 RN8 - 1976
Area of registered address:	Lancashire
Type of case:	Misconduct
Panel members:	Peter Swain (Chair, lay member) Lisa Punter (Registrant member) Andrew Macnamara (Lay member)
Legal Assessor:	Nigel Ingram
Panel Secretary:	Leigham Malcolm
Facts proved:	1a, 1b, 1c, 1d, 1e, 1f, 2a, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2i, 2j, 2m, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i, 3k, 3m, 3n, 3o & 4
Facts not proved:	2k, 2l, 2n, 3j & 3l
Fitness to practise:	Impaired
Sanction:	Strike-off
Interim order:	Interim Suspension Order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed that the Notice of Meeting had been sent to Mrs Parr's registered email address on 29 April 2021. The panel took into account that the Notice of Meeting provided details of the allegations as well as a timeframe for a virtual meeting.

Further, the panel noted that the Notice of Meeting was also sent to Mrs Parr's representative on 29 April 2021. Given that Mrs Parr is represented the panel considered it may be in Mrs Parr's interest to alert her representative to the fact that the substantive meeting was about to take place, and provide them with an opportunity to make any written representations or submissions. The panel secretary sent an email to Mrs Parr's representative, inviting them to respond with any written submissions, but received no response.

The panel accepted the advice of the legal assessor.

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

Details of charge

That you a registered nurse, whilst employed as the Registered Manager of Silver Birch Lodge (the "Home");

1. *In relation to fitting a catheter to Resident A on 24 December 2018;*

    (a) Failed to obtain GP advice before fitting the catheter
    (b) Failed to obtain a valid prescription before fitting the catheter
    (c) Failed to inform Resident A of the risks involved before fitting the catheter
    (d) Failed to record in Resident A's care plan the date the catheter was fitted

(e) Failed to record a rationale for fitting the catheter within Resident A's documentation
(f) Failed to explore with Resident A any alternative options before fitting the catheter

2. *Between the 7th August 2018 and the 9th August 2018;*

(a) Failed to ensure that equipment was used safely
(b) Failed to ensure that care and treatment was provided safely
(c) Failed to ensure that risks to health and safety were adequately assessed
(d) Failed to ensure that adequately protect people from the risk and spread of infection
(e) Failed to ensure that risk assessments were always documented
(f) Failed to ensure that medicines were managed safely by the service
(g) Failed to ensure that records were always recorded contemporaneously and/or was an accurate reflection of the care provided and/or the support people required
(h) Failed to work with others in a timely manner to ensure that the responsibility for care and treatment of people that lived at that Home was shared with others
(i) Failed as reasonably practicable to minimise the risk of avoidable harm to people at the service
(j) Failed to ensure that staff at the Home had the requisite skills and competence to support people who lived at the home
(k) Failed to ensure that a person centred care was consistently provided
(l) Failed to consistently carry out a collaborative assessment of needs and preferences of the person and designed care and treatment to achieve the person's preference

(m) Failed to ensure that audit systems were effective

(n) Failed to ensure that notifications were carried out when required

3. *Between the 11th February 2019 and the 15th February 2019;*

(a) Failed to ensure that medicines were consistently managed safely

(b) Failed to adequately assess risk and monitor safety at the service

(c) Failed to ensure that people were safeguarded from the risk of harm and abuse

(d) Failed to ensure that staff were of good character and/or suitable for their role and responsibilities

(e) Failed to ensure that all staff had received such appropriate support and training necessary to enable them to carry out the duties they are employed to perform

(f) Failed to ensure that all staff were working within the principles of the Mental Capacity Act and the correct DoLS were in place

(g) Failed to ensure that systems in place for referral to external services were effective to manage people's needs

(h) Failed to ensure consistency in assessing people's needs and choices and/or delivering care in line with standards and/or guidance

(i) Failed to ensure people were supported to express their views and be involved in making decisions about their care

(j) Failed to ensure a consistent approach to respecting and promoting people's privacy, dignity and independence

(k) Failed to ensure that people were administered their medication when required

(l) Failed to ensure that people received consistent person-centred care

(m) Failed to assess, monitor and mitigate the risks relating to the health and welfare of people using the service

(n) Failed to maintain an accurate record in respect of each person using the service

(o) Failed to assess, monitor and improve the service

4. Between the 9th August 2018 and the 15th February 2019, failed to take any, or any sufficient, action to improve the service at the Silver Birch Lodge following notification of breaches of regulations by the CQC

In light of the above charges your fitness to practise is impaired by your misconduct

Decision and reasons on amending the charge

The panel, of its own volition, considered amending the stems of charges 2 and 3 to more accurately reflect the evidence in relation to the time period identified.

Original Charge:

2. Between the 7th August 2018 and the 9th August 2018;

3. Between the 11th February 2019 and the 15th February 2019;

Proposed amended Charge:

2. Between the 7th August 2018 and the 9th August 2018 the CQC conducted an inspection of the Home which found evidence that you;

3. Between the 11th February 2019 and the 15th February 2019 the CQC conducted an inspection of the Home which found evidence that you;

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

The panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Parr and no injustice would be caused to either party by the proposed amendment. The evidence in the case as disclosed to Mrs Parr was derived entirely from the CQC inspections; it was clear to the panel that the case brought by the NMC was intended to be based on the findings of those

inspections, covering events that would have taken place before the time-frames set out in the original charges. The panel therefore decided to amend the stems of Charges 2 & 3 to ensure clarity and accuracy.

Background

The NMC received a referral from the Care Quality Commission (CQC) on 14 February 2019 concerning Mrs Parr's practice as Nurse and Registered Manager at Silver Birch Lodge, Holt Green Residential Homes Limited, Ormskirk, Lancashire ("the Home").

On 7 & 9 August 2018 an unannounced inspection was carried out by the CQC at the Home, and the Home was rated 'requires improvement'. The CQC's Inspection Report dated 31 October 2018 was subsequently published.

The CQC carried out another unannounced inspection at the Home on 11, 12 & 13 February 2019 at which an inspector identified that a catheter had been administered to Resident A without a prescription. It is alleged that on 24 December 2018 a catheter was administered to Resident A by Mrs Parr in the absence of a prescription and/or in the absence of a discussion with Resident A's General Practitioner (GP). This inspection also found a number of wide ranging concerns including about safe delivery of care and safe administrations of medication. Some of these concerns were matters that remained outstanding following the August 2018 inspection.

On 14 February 2019 the CQC wrote to Mrs Parr outlining the concerns and incidents that they observed in a letter of intent. A referral was also made to the Nursing and Midwifery Council (NMC) in relation to Resident A.

On 15 February 2019 another unannounced inspection was carried out at the home and the CQC received an action plan from Mrs Parr as requested in their letter of intent. The CQC Inspector spoke with Mrs Parr at the Home in relation to the action plan and to determine if the actions had been put in place.

On 18 February 2019 the CQC sent a letter to the Home to impose conditions on it as a

service provider.

On 22 February 2019 a Notice of Proposal to cancel the Mrs Parr's registration was submitted by the CQC.

On 26 March 2019 a formal Notice of decision to cancel Mrs Parr's registration as a registered manager in respect of a regulated activity was submitted by the CQC.

On 5 April 2019 the second CQC Inspection Report dated 5 April 2019 was published. The Home was closed down on 23 April 2019.

On 17 April 2019 Mrs Parr's representatives submitted representations on her behalf in which she accepted the concerns around the catheterisation of Resident A.

On 18 December 2019 Mrs Parr's representative submitted a copy of the Regulatory Concerns Response Form ("the Response Form") dated 3 December 2019, together with supporting documentation including:

- a Safe Administration of Medicines Certificate;
- a Safeguarding of Vulnerable Adults Certificate; and
- a Certificate of attendance at a presentation on 'Medicines use in care homes'.

Within the Response Form Mrs Parr accepted that concerns about Resident A and concerns around failures to ensure safe administration of medications were 'correct and fair'.

In response to the allegations around the catheterisation of Resident A Mrs Parr explained that Resident A had been living in the home for over 14 months by Christmas 2018, and that she had built up a close relationship with her and her family. Mrs Parr further explained that Resident A was 'desperate' to go home for Christmas and, in the context of witnessing her distress, it occurred to her she could catheterise Resident A.

Mrs Parr explained that she had administered hundreds of catheters in her nursing career and felt it was a routine procedure. Mrs Parr reported that Resident A provided consent, in the presence of a colleague who also assisted with positioning Resident A. Mrs Parr explained that it did not occur to her to contact the GP and said that she had allowed 'her heart to rule her head'. Mrs Parr reported being under a lot of stress at the time, had been working 14 hour shifts consecutively, and her judgement was impaired.

Mrs Parr's representative informed the NMC that Mrs Parr subsequently undertook training suggested by the CQC including safeguarding and continence care. The NMC was also informed that Mrs Parr retired after the Home was closed and has no intention of working as a nurse in the future.

Mrs Parr has not submitted any other comments on the other concerns raised by the CQC inspections. She was invited to indicate whether she accepted each of the final set of charges for this hearing, but did not respond.

Legal Advice

In reaching its decision on facts the panel took into account all the documentary evidence in the case together with the written submissions from the NMC. In addition, the panel considered the written responses by the Mrs Parr and her solicitor representatives.
A significant part of the evidence placed before the panel were the detailed reports from the CQC which underpinned many of the allegations.

The panel were advised by the legal assessor that these reports fell under the heading of hearsay evidence which the panel were entitled to consider under Rule 31(1) NMC (FTP) 2004 *" subject only to the requirements of relevance and fairness "* in support of the NMC's case. The panel's approach to that evidence should be informed by that set out in the case El Karout v NMC [2019] EWHC 28 (Admin) by Mr Justice Spencer in conjunction with the factors identified in NMC v Ogbonna [2010] EWCA Civ. 2016.

Firstly, they should consider its admissibility and the panel were helped in this by the fact that the documents were reports prepared by CQC staff, who could be considered experts, and addressed issues in these proceedings. Plainly they were highly relevant in these

proceedings and the Mrs Parr had been supplied with them. The panel determined that they were admissible.

Secondly, in considering the weight that should be attached to them as evidence it was the panel's view that it would be substantial. They placed great weight on the fact that the inspections were carried out by the CQC who are a specialist agency tasked with this duty. The Mrs Parr had been supplied with them and provided an opportunity to respond. The legal assessor also advised the panel that where there was further evidence from other witnesses and sources they could rely upon that evidence as corroborating the CQC reports.

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

Decision and reasons on facts

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

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

Charge 1a

That you a registered nurse, whilst employed as the Registered Manager of Silver Birch Lodge (the "Home");

1. *In relation to fitting a catheter to Resident A on 24 December 2018;*

    (a) Failed to obtain GP advice before fitting the catheter

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Ms 1, the 'Catheter Care Guidance' and the Royal College of Nursing's guidance in relation to catheterisation and consent.

The panel noted Ms 1's statement in which she stated:

> *"When we discussed this with the Mrs Parr, she explained that Resident A had wanted to go home to her family over the Christmas period, but was concerned about needing assistance to use the toilet and her and her family not being able to support this. We questioned whether the Registrant saw the risks of administering this catheter without first consulting with a GP. The Registrant confirmed that she did now, however she was in a high emotional state. The Registrant was struggling with mental health problems due to family and financial issues. She responded to us with words to the effect that she had not thought things through when she administered the catheter."*

It also bore in mind Mrs Parr's acceptance within the Response Form that she did not obtain advice from Resident A's GP before fitting the catheter. On the evidence before it the panel found this charge proved.

Charge 1b

> *(b) Failed to obtain a valid prescription before fitting the catheter*

The charge is found proved.

In reaching its decision, again, the panel took into account the witness statement of Ms 1 and Mrs Parr's acceptance within the Response Form that she did not consult the GP. Given Mrs Parr's acceptance that she did not consult the GP, and in the absence of a prescription, the panel found this charge proved.

Charge 1c

(c) Failed to inform Resident A of the risks involved before fitting the catheter

This charge is found proved

In reaching its decision the panel took into account the witness statement of Mrs 2 in which she stated:

"I asked the Registrant about risk assessments and a capacity assessment for Resident A. The Registrant stated that she had not undertaken any of these things, and she asked whether she should do them now. I informed her that she could not do them in hindsight, as they would not be relevant."

Mrs 2's statement clearly sets out that Mrs Parr failed to undertake a risk assessment or capacity assessment for Resident A and, on the balance of probabilities, the panel found this charge proved.

Charge 1d

(d) Failed to record in Resident A's care plan the date the catheter was fitted

This charge is found proved

In reaching its decision the panel took into account Resident A's patient notes and continence care plan. There was evidence before the panel of a contemporaneous note within Resident A's patient notes made by Mrs Parr. However, no note or record of the catheterisation had been made on Resident A's continence care plan. The insertion of a catheter was clearly relevant to continence care and so it was a failure not to record the insertion on the continence care plan, even if it was recorded in other notes.

In view of the evidence before it the panel found this charge proved.

Charge 1e

(e) Failed to record a rationale for fitting the catheter within Resident A's documentation

This charge is found proved

In relation to this charge the panel took account of Resident A's patient notes. It appeared that Mrs Parr had made notes, however, they did not include a rationale for the fitting of the catheter. The notes included reference to Resident A's plans to spend Christmas away from the Home but there was no clinical rationale in relation to catheterisation.

On the basis of the evidence before it the panel found this charge proved.

Charge 1f

(f) Failed to explore with Resident A any alternative options before fitting the catheter

This charge is found proved

In reaching its decision the panel took account of the witness statement of Ms 3 in which she stated:

"I believe that the Registrant would have been aware of other options, however, I cannot say for sure whether she would have offered these or used an alternative to the catheter if she had more time".

There was no evidence before the panel that Mrs Parr explored alternative options to catheterisation with Resident A. On the balance of probabilities, the panel found this charge proved.

Charge 2a

2. *Between the 7th August 2018 and the 9th August 2018 the CQC conducted an inspection of the Home which found evidence that you;*

    (a) Failed to ensure that equipment was used safely

This charge is found proved

In reaching its decision the panel had regard to the CQC report dated 31 October 2018 which set out the following in relation to the matter:

> *"Although people told us they felt safe, at this inspection in August 2018 we found people's safety was not always assured. Two people required specialist mattresses to maintain their skin integrity and reduce the risk of skin damage occurring. We looked at the equipment and saw it was set incorrectly. The mattresses were set at a weight heavier than the last recorded weight of both people. This posed the risk that the person's skin integrity would be compromised."*

The panel determined that it was more likely than not that Mrs Parr had failed to ensure that equipment was used safely. It therefore found this charge proved.

Charge 2b

> *(b) Failed to ensure that care and treatment was provided safely*

This charge is found proved

In reaching its determination the panel took account of the example of mattresses given in Charge 2a. The panel also took account of the findings of the medicines inspector, as set out in the CQC report:

> *"We found medicines were not always given to people when they needed them. On the day of the inspection six people were not given their morning medicines until between 2:30 -3:30pm. The manager explained to us that this was because when she had started the medicines round at 8:15am they were not awake. For some*

people it was important that they were given their medicines at a specific time. For example, two people were prescribed medicines at 12:00 noon. The medicine was not given them on the day of the inspection at the correct time. Other people were prescribed medicines, including antibiotics, to be given before food. We were told they were given these medicines with food. This means the medicines may not be effective. When people were given regular doses of pain killers staff did not record the time each dose was given and this meant that they could not show that a safe time interval had been left between doses.

The home did not have a system of identifying people before they administered medicines. It is best practice for a photograph of the person to be kept with their MARS so that staff giving medicines can easy identify the right person. This posed the risk agency staff would not be able to identify people easily. Four people were prescribed a powder thickener to be added to their drinks to reduce their risk of choking. The information about how thick to make people's drinks was in the kitchen. People were only identified by the room they were in and not by their names. If people moved rooms they were at risk of not being given the correct thickness drinks. During the inspection we found one of these people had recently moved rooms and the list had not been updated."

Overall, the CQC found that in respect of 'is the service safe' it required improvement. The panel was satisfied that Mrs Parr failed to ensure that care and treatment was provided safely.

Charge 2c

(c) Failed to ensure that risks to health and safety were adequately assessed

This charge is found proved

In reaching its decision the panel had regard to the CQC report dated 31 October 2018 which highlighted that the service 'required improvement' in relation to safety and effectiveness and set out the following in relation to the matter:

“We found risk assessments were not always carried out to identify risk and ensure people received the care and support they required. In one care record we saw no risk assessments for moving and handling, nutritional risk, bedrails or equipment the person used. Staff we spoke with told us the person required a hoist and wheelchair to help them mobilise and bedrails when they were in bed to keep them safe. Staff also told us the person had a small appetite. We also saw there was no falls risk assessment in the care record we viewed. During the inspection we saw the person using the wheelchair.

We found the home was not always secure. The grounds were not fenced and we saw some ground floor windows were open wide enough for unauthorised people to enter and external doors were sometimes left open. For example, we saw an external door in a laundry was open for over an hour, a door in a conservatory was open throughout the day. This posed the risk that unauthorised people could enter the home unobserved.

We discussed this with the registered manager who told us the doors were not usually open, this was because of the hot weather, windows were locked by staff at night and staff were in the corridors and would see unauthorised people entering. In addition, we saw staff were not always present in the dining room where people were sitting. There was no call bell in place to enable people to summon help. We discussed this with the registered manager who told us the kitchen staff were in the kitchen and would note if people needed help. We asked the registered manager if they had carried out risk assessments to assess the risk and identify what risk controls were needed. The registered manager said they had not, but they would complete this.”

The panel determined that it was more likely than not that Mrs Parr had failed to ensure that risks to health and safety were adequately assessed. It therefore found this charge proved.

Charge 2d

(d) Failed to ensure that adequately protect people from the risk and spread of infection

This charge is found proved

In reaching its decision the panel had regard to the CQC report dated 31 October 2018 which set out the following in relation to concerns around the risk of spread of infection:

> *"We looked around the home to check it was a clean environment for people to live in. We saw the home was visibly clean but noted concerns with the management of infection control. For example, a bin in a sluice area was not foot operated and needed to be opened by hand and clean clothes, tablecloths and towels were present in a laundry when soiled washing was in the machine. The staff member we spoke with told us soiled washing was placed in the washing machine while clean clothes were present in the laundry. This posed a risk of cross infection. In addition, we noted two yellow waste bins in the car park were unlocked and there were yellow bags of waste within them. The bins could be accessed by members of the public. This placed people at risk of cross infection."*

The panel determined that it was more likely than not that Mrs Parr had failed to adequately protect people from the risk and spread of infection. It therefore found this charge proved.

Charge 2e

(e) Failed to ensure that risk assessments were always documented

This charge is found proved

The panel had regard to the CQC report dated 31 October 2018 which set out the following in relation to the documentation of the risk assessments:

"In addition, we saw staff were not always present in the dining room where people were sitting. There was no call bell in place to enable people to summon help. We discussed this with the registered manager who told us the kitchen staff were in the kitchen and would note if people needed help. We asked the registered manager if they had carried out risk assessments to assess the risk and identify what risk controls were needed. The registered manager said they had not, but they would complete this."

In addition, the panel bore in mind Mrs 2's evidence that Mrs Parr suggested retrospectively documenting risk assessments:

"I asked the Registrant about risk assessments and a capacity assessment for Resident A. The Registrant stated that she had not undertaken any of these things, and she asked whether she should do them now. I informed her that she could not do them in hindsight, as they would not be relevant."

The panel determined that it was more likely than not that Mrs Parr had failed to ensure that risk assessments were always documented, and it found this charge proved.

Charge 2f

(f) Failed to ensure that medicines were managed safely by the service

This charge is found proved

The panel took account of the CQC report dated 31 October 2018 which set out the following in relation to the safe management of medications:

"We saw audits completed by the registered manager and found these to be ineffective. For example, the medicines audits had not identified the errors we had seen on inspection. Bed audits did not check that pressure relieving equipment was set to the correct weight for peoples use and care records audits had not identified all the concerns we had identified in the care records we viewed. In addition, the audits carried out had not identified that risk assessments relating to the

environment and people who used the service had not been completed. The infection control audit had not identified the risk of cross infection present at the home."

"We found medicines were not always given to people when they needed them. On the day of the inspection six people were not given their morning medicines until between 2:30 -3:30pm. The manager explained to us that this was because when she had started the medicines round at 8:15am they were not awake. For some people it was important that they were given their medicines at a specific time. For example, two people were prescribed medicines at 12:00 noon. The medicine was not given them on the day of the inspection at the correct time. Other people were prescribed medicines, including antibiotics, to be given before food. We were told they were given these medicines with food. This means the medicines may not be effective.

When people were given regular doses of pain killers staff did not record the time each dose was given and this meant that they could not show that a safe time interval had been left between doses. The home did not have a system of identifying people before they administered medicines. It is best practice for a photograph of the person to be kept with their MARS so that staff giving medicines can easy identify the right person. This posed the risk agency staff would not be able to identify people easily. Four people were prescribed a powder thickener to be added to their drinks to reduce their risk of choking. The information about how thick to make people's drinks was in the kitchen. People were only identified by the room they were in and not by their names. If people moved rooms they were at risk of not being given the correct."

"During the inspection we found one of these people had recently moved rooms and the list We did stock checks on over 40 different medicines. We compared the stock of medicines in the home with the amount we expected to be in the home if the medicines had been given as prescribed and as signed for on the MARS. We found for 37 of the medicines we checked had not been given as prescribed. In most instances there were more tablets in stock than expected. This indicated the medicines had not been given as prescribed by the doctor. We also found instances

of less medicines being in stock than expected indicating that medicines could not be accounted for.

We noted staff had signed for more medicines than had been supplied. This meant it was not possible that people were given the correct doses of their medicines. Records about the administration of medicines were not well completed and did not evidence that medicines could be accounted for or were administered as prescribed. For example, records made on the MARS by nurses, showed that one person, over an eight-day period, had been given the wrong dose of their medicine on four days. For another person, over a 21-day period they had been given the wrong dose of their medicine on five days. It was not possible to confirm this by checking the stock because the stock balances were not accurate. For instance, the records showed that one person started the period with 28 tablets and three were given but 121 tablets were in stock for them on the day of the inspection. We saw numerous missing signatures on the MARS. Sometimes it was not possible to tell if the medicines had been given and not signed for or not given at all. When it was possible to check the stock levels we found the doses had not been given. When prescribed thickening agents and creams were applied we found that nurses and senior carers were signing the MARS even though they had not carried out the task, this meant the records were not accurate and people may not have had creams applied or fluids thickened as recorded.

We found that controlled drugs, drugs which have very strict regulations about their storage and records to ensure they are not misused, were not recorded in the controlled drug register as is required by law. Other medicines were not stored safely. For example, we saw people had creams on their window ledges in the bedrooms and we noted tins of thickener in two people's bedrooms which were not locked away. This practice was identified as dangerous by the National Patients Safety Agency in 2015. We also found an epipen, used in an emergency situation to treat a severe allergic reaction, was stored incorrectly in the fridge. This meant it may not deliver the correct dose when it was needed. The manager told us she was unaware that the device should not be kept in a fridge.

Waste medicines were not locked away securely as recommended by the NICE guidelines. We found two boxes of diamorphine injections left on top of a cupboard in the medicines room and several other boxes of diamorphine stored in the general medicines stock cupboard. Diamorphine is a controlled drug which is subject to strict legal storage conditions to ensure they are not misused. The medicines room was accessible via a key pad rather than a key. This meant that staff who did not have authority to handle medicines could access the room posing a risk of medicines being misused.

There was a lack of information for nurses and senior carers to follow to ensure that medicines which were prescribed "when required" were given safely and consistently. There was no information recorded to help staff select the higher or lower doses when medicines were prescribed with a choice of dose. There was no information recorded to guide staff where and how often to apply creams and other external preparations. We saw one person was being given all their medicines via a special tube but there was no information from a pharmacist to guide the nurses how to give medicines safely via the tube."

The panel determined that it was more likely than not that Mrs Parr had failed to ensure that medicines were safely managed, and it found this charge proved.

Charge 2g

(g) Failed to ensure that records were always recorded contemporaneously and/or was an accurate reflection of the care provided and/or the support people required

This charge is found proved

The panel bore in mind the CQC's reporting on the safe management of medication, as outlined above. It also noted the CQC's reporting on 31 October 2018 around contemporaneous/accurate records, as follows:

"We noted one person needed help to eat by using a percutaneous endoscopic gastrostomy (PEG). This is a procedure used to support people to eat if they have

specific needs. The charts we viewed recorded that by midnight 800 mls was given to the person. The care plan instructed 1000 mls was to be given over 10 hours, from 8pm at night. We discussed this with the registered manager. They told us it was likely that staff were recording 800mls at midnight and this was being recorded incorrectly. We saw the care records instructed that the tube used should be flushed at specific times. The chart we viewed did not demonstrate the instructions had been followed. We discussed this with the registered manager who concluded that the record was incorrect."

"During this inspection we found care planning did not support the delivery of responsive care. Records contained conflicting or missing information. We noted a person lived with behaviours which may challenge. We looked at their care records and saw contradictory information was present. In one section of the care record it recorded the person did not have any distress, in a further part of the care record it recorded the person did have some distress and agitation. In addition, we found the person lived with a specific health condition. There was no guidance to instruct staff on the signs and symptoms the person may display if they became unwell. In the same care record, we saw the person required a soft diet and a thickened drink. Staff we spoke with told us this was dependent on the person's daily ability however the care record did not reflect this."

The panel determined that it was more likely than not that Mrs Parr had failed to ensure that records were always recorded contemporaneously and/or was an accurate reflection of the care provided and/or the support people required, and it found this charge proved.

Charge 2h

(h) Failed to work with others in a timely manner to ensure that the responsibility for care and treatment of people that lived at that Home was shared with others

This charge is found proved

The panel took account of the CQC report dated 31 October 2018 which stated the following:

> *"We found one person who lived at the home had bedrails in use on their beds. These are used to minimise the risk of falls from a bed. Two staff members told us the person did not have the mental capacity to consent to this and the bedrails were used to maintain their safety. We looked at the care records for the person and saw no mental capacity assessment had been carried out and no DoLS [Deprivation of Liberty Safeguards] application had been submitted to the Lancashire Local Authority for authorisation."*

The panel determined that it was more likely than not that Mrs Parr had failed to work with others in a timely manner to ensure that the responsibility for care and treatment of people that lived at that Home was shared with others, and it found this charge proved.

Charge 2i

(i) *Failed as reasonably practicable to minimise the risk of avoidable harm to people at the service*

This charge is found proved

The panel took account of the CQC report dated 31 October 2018 which stated the following:

> *"We looked at food and fluid charts relating to two people at the home. On one person's fluid charts we found one day when the total was not calculated. On two further charts we found the totals were incorrect. On one chart we saw recorded the total the person had drunk was 975 mls. We calculated the total found it to be 885 mls. On a further chart we saw recorded the total person had drunk 1004 mls. The entries on the charts indicated the person had drunk 50 mls and two sips of fluid."*

The panel determined that it was more likely than not that Mrs Parr had as reasonably practicable to minimise the risk of avoidable harm to people at the service, and it found this charge proved.

Charge 2j

(j) Failed to ensure that staff at the Home had the requisite skills and competence to support people who lived at the home

This charge is found proved

The panel took account of the CQC report dated 31 October 2018 which stated the following:

"Staff told us they received training to enable them to update and maintain their skills. All the staff we spoke with told us they could attend training and this was discussed with them at supervisions. Staff told us they enjoyed the training and they were reminded when they were required to update their skills. Staff told us they had completed training in areas such as moving and handling, safeguarding, first aid and fire safety. During the inspection we asked to see documentation to corroborate this. On the days of the inspection the training matrix was not available. The registered manager told us they would send the up to date training matrix to us. We viewed the training matrix provided to us by the registered manager. They told us this was up to date. We noted it recorded 15 staff at the home had not had training in Fire Safety and 12 staff had not had training in the Mental Capacity Act and DoLS. The maintenance person told us they had no training in safeguarding and the registered manager confirmed this."

The panel determined that it was more likely than not that Mrs Parr failed to ensure that staff at the Home had the requisite skills and competence to support people who lived at the home, and it found this charge proved.

Charge 2k

(k) Failed to ensure that a person centred care was consistently provided

This charge is found NOT proved

The panel considered there to be evidence before it that the Home usually delivered person-centred care. Although the CQC report dated 31 October 2018 highlighted some areas where the Home fell below standards, the panel considered those examples to be insufficient evidence that person-centred care was not consistently provided. It noted the following from the CQC report dated 31 October 2018:

> *"People told us they liked the meals provided. We saw a menu was in place and people told us if they did not like the meal provided, they could request an alternative. During the inspection we saw people were provided with a meal of their choice and hot and cold drinks were available. We found not everyone received person centred care during their meals. We observed one person at breakfast was given cereal but was not prompted to eat it. We saw the person did not eat their meal until a staff member came and supported them to eat. We noted a further person's care plan said they should be observed while they were eating and drinking. During the inspection we saw they were not consistently observed when they ate their breakfast.*
>
> *This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as person centred care was not consistently provided. We saw evidence people's nutritional needs were monitored. People were weighed to identify if they required further health professional advice to meet their nutritional needs. Staff told us they would support people to gain further professional advice if this was required. During the inspection we saw documentation which evidenced referrals were made to other health professionals if required. For example, we saw a referral had been made to a dietician to establish if the person required additional nutritional support.*
>
> *People told us they felt the care provided met their needs. One person told us, "It's fantastic here." A further person said, "My care is very good." Relatives told us they*

felt the care was good. Documentation showed people received professional health advice when this was required. For example, we saw documentation which evidenced people were referred to doctors and dieticians if this was required. Staff we spoke with were knowledgeable of the individual needs of the people they supported."

Although there were a few isolated incidents reported where person-centred care had not been provided, looked at overall, the panel considered that Charge 2k was not proved on the evidence before it.

Charge 2l

(l) Failed to consistently carry out a collaborative assessment of needs and preferences of the person and designed care and treatment to achieve the person's preference

This charge is found NOT proved

The panel took account of all the evidence before it including the CQC report dated 31 October 2018. Within the evidence before it the panel found numerous instances where care and treatment plans had been created to meet the needs and preferences of residents. The panel noted the incident reported by the CQC on 31 October 2018, however, it determined that one incident did not amount to a consistent failure.

Charge 2m

(m) Failed to ensure that audit systems were effective

This charge is found proved

The panel took account of the CQC report dated 31 October 2018 which stated the following:

"Audits and checks carried out at Silver Birch Lodge had not identified some of the issues we identified on inspection. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw audits completed by the registered manager and found these to be ineffective. For example, the medicines audits had not identified the errors we had seen on inspection. Bed audits did not check that pressure relieving equipment was set to the correct weight for peoples use and care records audits had not identified all the concerns we had identified in the care records we viewed. In addition, the audits carried out had not identified that risk assessments relating to the environment and people who used the service had not been completed. The infection control audit had not identified the risk of cross infection present at the home."

The panel determined that it was more likely than not that Mrs Parr failed to ensure that audit systems were effective, and it found this charge proved.

Charge 2n

(n) Failed to ensure that notifications were carried out when required

This charge is found NOT proved

The panel took account of the CQC report dated 31 October 2018 which stated the following:

"It is a requirement that the Care Quality Commission is informed of certain events that occur in care homes. During this inspection we identified that the registered manager had not reported to the CQC a serious injury. We discussed this with the registered manager who told us they were aware this should have been submitted, but they had over looked this."

Within the evidence before the panel there was only evidence of one instance where the CQC had not been informed of a serious incident, whereas the charge was to the effect that there were multiple failures. The panel was of the view that evidence of one instance was insufficient to find this charge proved.

Charge 3a

3. Between the 11th February 2019 and the 15th February 2019 the CQC conducted an inspection of the Home which found evidence that you;

(a) Failed to ensure that medicines were consistently managed safely

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which outlined numerous instances of failures to ensure that medicines were consistently managed safely:

"The provider failed to ensure service users were protected from harm or serious risk of harm in relation to the safe management of medicines. We found examples were people who lived at the service had not received their prescribed medicines. For example, one person was not given eye drops for glaucoma for 21 consecutive days. Not having eye drops for glaucoma regularly reduces the effectiveness of the eye drop, potentially increasing the risk of the person developing glaucoma related blindness and exposing them to the risk of harm. Another person had not received their prescribed Parkinson's disease medicines at times specified by the consultant neurologist. Parkinson's disease symptoms such as slower movement, known as the 'off time' period occurs commonly just prior to taking the next dose of the treatment. Delaying the administration of this medication may increase the risk of an off period and the health and wellbeing of the individual.

- *Medicines systems were not adequately audited and therefore failings had not been identified by the provider.*

- *Staff responsible for the administration of medicines had not received training or been checked for competency in relation to the safe administration of medicines.*
- *People's medicines were not always stored at a safe and correct temperature. This meant that medicine properties and potency could have changed and therefore not been safe to administer to people that lived at the service and could have been less effective."*

The panel determined that it was more likely than not that Mrs Parr failed to ensure that medicines were consistently managed safely, and it found this charge proved.

Charge 3b

(b) Failed to adequately assess risk and monitor safety at the service

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which outlined numerous instances of failures to adequately assess risk and monitor safety at the service:

"Assessing risk, safety monitoring and management

People had been exposed to the risk of avoidable harm because the provider had not sufficiently identified and managed risks to individuals. For example, one person was found by the inspection team on day one of the inspection to be entrapped in a bedrail that did not have a safety bumper. The provider failed to act on the information shared to them about the individual until the same person was again identified by the inspection team on day two of the inspection to be entrapped in the same bedrail. Subsequently the provider then transferred the individual into a different bedroom and provided different equipment without any formal risk assessment or care planning. The individual then had a fall in their bedroom and sustained bruising to their hand.

We found people's risk assessments were not always updated after they had fallen. This meant the provider did not ensure risks to the individual had been considered and, where possible, reduced. Another person's care plan showed they required bedrail bumpers to prevent entrapment or injury when in bed. We found bedrail bumpers had not been provided. Another person had fallen from their wheelchair and the incident had not been recorded in their care plans or risk assessments to show how further risk of falling would be managed or reduced. The provider and staff lacked understanding and knowledge of how to effectively risk assess. During the inspection external health and social care professionals were asked by commissioners to provide support and guidance at the service to help reduce the risk of further avoidable harm. The provider agreed to engage with services offered.

The provider failed to undertake robust maintenance checks of the environment including bedrail and fire safety. We looked at maintenance, equipment servicing and fire prevention records. Areas highlighted to require action by the fire safety officer in September 2018 had not been addressed. We found people who lived at the service were at risk of harm in the event of a fire. The provider's emergency continuation plan had not been updated since 2016 and did not provide up to date information to assist staff in the event of an emergency and need for evacuation. We informed Lancashire Fire and Rescue of our findings."

The panel determined that it was more likely than not that Mrs Parr failed to adequately assess risk and monitor safety at the service, and it found this charge proved.

Charge 3c

(c) Failed to ensure that people were safeguarded from the risk of harm and abuse

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which outlined numerous instances of failures to ensure that people were safeguarded from the risk of harm and abuse:

“Systems and processes to safeguard people from the risk of abuse

The provider failed to ensure people who lived at the service were safeguarded from the risk of avoidable harm. One person had been reported to have frequent falls. The falls log for the individual showed they had 11 falls from 12 September 2018 to 17 September 2018. The provider had not informed the local safeguarding authority or consulted the safeguarding triage tool in line with their safeguarding processes.

We found an individual had received unlawful treatment. We escalated this to the local safeguarding authority for investigation.

The provider failed to ensure people were provided appropriate equipment to prevent them falling from bed. Bedrails were being used without full consideration of a person's needs or preferences. When used inappropriately bedrails can be a form of mechanical restraint and the provider failed to demonstrate comprehensive assessments to show why bedrails were routinely used for 19 out of 21 people who lived at the service.

Not all staff had completed safeguarding training. However, they were able to tell us how they would respond to any concerns. The provider had failed to ensure people were safeguarded from the risk of harm and abuse. This was a breach of regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.”

The panel determined that it was more likely than not that Mrs Parr failed to ensure that people were safeguarded from the risk of harm and abuse, and it found this charge proved.

Charge 3d

(d) Failed to ensure that staff were of good character and/or suitable for their role and responsibilities

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which outlined the following in relation to staffing and recruitment at the Home:

> *"Staffing and recruitment*
>
> *The provider failed to consistently undertake safety checks when they recruited staff. We asked to look at five staff files. However, the provider told us staff recruitment files were held off site and we were only provided with three of the five requested staff files. We found four people who worked at the service or had access to service user or staff confidential data had not undertaken criminal record checks as part of the Disclosure and Barring Service (DBS) process. These checks are to ensure people who work with vulnerable adults are of good character.*
>
> *The provider had failed to ensure that staff were of good character and suitable for their role and responsibilities. This was a breach of regulation 19 of the Health and Social Care Act (Regulated Activities)*
> *Regulations 2014."*

The panel determined that it was more likely than not that Mrs Parr failed to ensure that staff were of good character and/or suitable for their role and responsibilities, and it found this charge proved.

Charge 3e

(e) Failed to ensure that all staff had received such appropriate support and training necessary to enable them to carry out the duties they are employed to perform

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which outlined the following:

"Staff support: Induction, training, skills and experience

The registered provider had failed to provide care staff and nurses with adequate induction, training and development to ensure they could effectively undertake their roles.

We found significant gaps in training and competence checks in areas that the provider had deemed mandatory for the roles. For example, subjects such as moving and handling, safeguarding, nutrition, skin care, medicines administration and fire awareness. The lack of training had contributed to the failures we found in the safe management of medicines, the unsafe fire safety practices, the shortfalls in falls prevention and bedrail safety. We asked the registered provider to take immediate action to prioritise training in these key areas and they started to take action during our inspection.

Supervisions and appraisals were not held on a regular basis and the provider's policy and procedure in relation to staff support was not accessible. Some staff were not able to recall when they last had supervision. There was a failure to ensure that all staff had received such appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014."

The panel determined that it was more likely than not that Mrs Parr failed to ensure that all staff had received such appropriate support and training necessary to enable them to carry out the duties they are employed to perform, and it found this charge proved.

Charge 3f

(f) Failed to ensure that all staff were working within the principles of the Mental Capacity Act and the correct DoLS were in place

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which outlined the following in relation to the MCA and DoLS at the Home:

"The registered manager and staff members lacked understanding of the MCA and DoLS. The registered manager had applied for DoLS authorisation from the local authority. However, they had applied to deprive people of their liberties even when they were able to consent to their own care and were not restricted. Mental capacity assessments were generic and not decision-specific. Three people had their consent forms signed by family members; however, there was no evidence whether the people lacked mental capacity to make those decisions and there was no evidence the correct lasting power of attorney was in place to allow family members to sign consent."

The panel determined that it was more likely than not that Mrs Parr failed to ensure that all staff were working within the principles of the Mental Capacity Act and the correct DoLS were in place, and it found this charge proved.

Charge 3g

(g) Failed to ensure that systems in place for referral to external services were effective to manage people's needs

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which outlined the following:

"Staff working with other agencies to provide consistent, effective, timely care

The systems in place for referrals to external services, such as GPs, were not always effective. We had to ask the registered manager to seek specialist support for people who lived at the service during our inspection. This included people who

were at risk of falls and unintentional weight loss. Guidance from healthcare professionals was not always sought or followed, as discussed in the 'safe' section of this report.

The registered manager had not sought support from external agencies to effectively manage people's needs."

The panel determined that it was more likely than not that Mrs Parr failed to ensure that systems in place for referral to external services were effective to manage people's needs, and it found this charge proved.

Charge 3h

(h) Failed to ensure consistency in assessing people's needs and choices and/or delivering care in line with standards and/or guidance

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which outlined the following:

"Assessing people's needs and choices; delivering care in line with standards, guidance and the law

While care and support had been planned, people's care was not always delivered and monitored in line with current evidence-based guidance, legislation, standards and best practice. Assessments had been carried out and some obtained from other health and social care professionals and used to develop care plans, however this was not always consistently followed. Staff were unable to apply learning in line with best practice. This does not promote good outcomes for people or support a good quality of life."

The panel determined that it was more likely than not that Mrs Parr failed to ensure consistency in assessing people's needs and choices and/or delivering care in line with standards and/or guidance, and it found this charge proved.

Charge 3i

(i) Failed to ensure people were supported to express their views and be involved in making decisions about their care

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which stated:

> *"Supporting people to express their views and be involved in making decisions about their care*
>
> *People were not always involved in making decisions about their care. Not all the people we spoke with believed they were involved in decisions about their care and support. Comments we received included, "No one has spoken to me about my care." And, "If they come to me we can discuss my care; however no one has come to me."*
>
> *"Planning personalised care to meet people's needs, preferences, interests and give them choice and control*
>
> *The provider failed to ensure people who lived at the service consistently received person-centred care. We found people's individual needs and associated risks were not always identified or considered. For example, failings around individuals' care in relation to inaccurate medicines management, falls and inappropriate use of bedrails as outlined in the 'safe' section of this report. We saw care plans did not always reflect people's choices, wishes and preferences and things that were important to them."*

The panel determined that it was more likely than not that Mrs Parr failed to ensure people were supported to express their views and be involved in making decisions about their care, and it found this charge proved.

Charge 3j

(j) Failed to ensure a consistent approach to respecting and promoting people's privacy, dignity and independence

This charge is found NOT proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which raised the following points:

> *"Respecting and promoting people's privacy, dignity and independence*
>
> *People told us their right to privacy and confidentiality was respected. However, we noted personal care records were in the registered manager's office which was left unlocked when unattended. We discussed this with the registered manager as records should be kept safely and securely who gave assurance that records would be stored safely.*
>
> *People who used the service were treated with dignity and respect. We saw staff knocked on doors before entering bedrooms and bathrooms. However, care staff had not received up to date training in relation to equality and diversity and human rights to increase their awareness of people's rights. We noted people were not always supported to manage their health conditions by ensuring they had their medicines.*
>
> *Staff promoted people's independence and encouraged them to do things for themselves. We saw the registered manager encouraged some people to help with chores in the home. People also told us they were encouraged to go out in the community with their families if they wanted to."*

The panel bore in mind that the CQC had raised concerns within its report around personal care records that were in the registered manager's office which was left unlocked when unattended. However, it considered on the whole the comments were positive about how service users were respected, and the report specifically found that 'people who used the service were treated with dignity and respect'. The panel reached the view that there was insufficient evidence before it of failures to ensure a consistent approach to respecting and promoting people's privacy, dignity and independence to find this charge proved.

Charge 3k

(k) Failed to ensure that people were administered their medication when required

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which stated:

> *"We observed positive interactions with staff during our inspection. Staff presented as kind and caring. However, some of our findings did not demonstrate that the home was caring. For example, we found concerns that people were not given their medicines when they needed them which may cause a deterioration to their conditions."*

The panel determined that it was more likely than not that Mrs Parr failed to ensure that people were administered their medication when required, and it found this charge proved.

Charge 3l

(l) Failed to ensure that people received consistent person-centred care

This charge is found NOT proved

In relation to this charge the panel took account of all of the evidence before it. It took account of the definition of person-centred care, which the panel understood to be:

> *"Person-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs."*

The panel noted that there was some evidence of shortcomings in the delivery of person-centred care. However, there was also substantial positive evidence of person centred-care in other areas. The panel took into account the comments in the CQC report that service users were treated with dignity and respect. On balance, the panel found this charge not proved.

Charge 3m

> *(m) Failed to assess, monitor and mitigate the risks relating to the health and welfare of people using the service*

This charge is found proved

The panel took account of the CQC report dated 5 April 2019 which stated:

> *"There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements*
>
> - *The service was not well-led. The registered manager lacked knowledge around the regulations, legislation and best practice guidance to ensure the service improved.*
> - *The service had continued to fail since the last inspection. This showed there were inadequate management systems at the service.*
> - *Leadership within the service was poor. Staff were not led by best practice.*
> - *There was a significant lack of understanding around risk management.*

- *Those people with complex needs were at risk of receiving inappropriate or inadequate care and support."*

The panel determined that it was more likely than not that Mrs Parr failed to assess, monitor and mitigate the risks relating to the health and welfare of people using the service, and it found this charge proved.

Charge 3n

(n) Failed to maintain an accurate record in respect of each person using the service

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which set out:

"Care records did not always reflect people's needs. The provider did not always act on their duty of candour responsibilities in relation to escalation of people's change in health needs and reporting of incidents. For example, one person who lived at the service had not received their eye treatment for 21 consecutive days which meant they were at risk of becoming blind. Two people had not received their anti-coagulant medication as prescribed and this placed them at serious risk of avoidable harm. Instances of medicine omission had not been escalated to the person's GP for review of their health and well-being."

The CQC inspection report also contained multiple examples of inaccurate record keeping. For example, a MAR chart did not show the time of medication administration. In another case it was not clear whether Warfarin had been administered. In another case falls were not recorded in the 'falls assessment' or the 'review of care' plan. There was no record of post falls observations in the care records. These and other examples were more than minor administrative oversights. They were omissions and inaccuracies that potentially had a direct impact on the safety of patient care. The panel determined that it was more likely than not that Mrs Parr failed to maintain an accurate record in respect of each person using the service, and it found this charge proved.

Charge 3o

(o) Failed to assess, monitor and improve the service

This charge is found proved

In relation to this charge the panel had regard to the CQC report dated 5 April 2019 which stated:

> *"Continuous learning and improving care and working in partnership with others*
>
> *Quality assurance processes were not effective and did not identify the issues we found during this inspection. The service had not adopted a learning culture. Local authority and health commissioners told us the provider previously failed to engage in resourceful initiatives such as training programmes and best practice committee places offered to them. The provider failed to assess, monitor and improve the service and was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014."*

The panel determined that it was more likely than not that Mrs Parr failed to assess, monitor and improve the service, and it found this charge proved.

Charge 4

4. Between the 9th August 2018 and the 15th February 2019, failed to take any, or any sufficient, action to improve the service at the Silver Birch Lodge following notification of breaches of regulations by the CQC

This charge is found proved

In relation to this charge the panel took account of both inspection reports by the CQC dated 31 October 2019 and 5 April 2019. The report dated 5 April 2019 concluded:

> *"Our last inspection report for this service was published on 31 October 2018 and the rating was 'Requires Improvement' across all domains. There were three breaches of regulations 9,12,17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care, safe care and treatment and good governance. The provider was also in breach of regulation 18 of the Health and Social Care Act 2008 Registration Regulations 2009, Notifications of other incidents. Following the last inspection, we took enforcement action and issued the registered provider with warning notices in relation to medicines management, risk assessment and good governance. We also asked the registered provider to tell us what actions they would take to comply with these regulations.*
>
> *At this inspection in February 2019, we found the provider had made some improvements in relation to the prevention and control of infection. However, we found continuing areas for improvement in relation to governance arrangements, risk assessment and medicines management. Our findings showed there were areas which had deteriorated further and areas that required further improvements and improvements made needed to be imbedded and sustained. The service had deteriorated and was rated overall Inadequate."*
>
> *"The provider failed to ensure individual risks for people who lived at the service had been assessed and this placed them at significant risk of avoidable harm."*

There was evidence before the panel that Mrs Parr had failed to take any action in response to most of the recommendations made by the CQC in its inspection report of October 2018. In respect of some areas, the quality of service delivery had actually deteriorated. The CQC inspection report of 31 October 2018 gave very clear information about the areas of concern to be addressed. It was Mrs Parr's responsibility to act urgently on these areas in the interests of her residents. The findings of the 5 April 2019 inspection report clearly demonstrate that she failed in this responsibility. On the evidence before it, the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mrs Parr's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

The panel accepted the advice of the legal assessor who drew the panel's attention in particular to the case of Roylance vs GMC (No.2) [2000] 1 AC 311, which defines misconduct as a "*word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. Such falling short as is established should be serious".* In addition he directed the panel to the case of Calhaem v GMC [2007] EWHC 2606 (Admin) where it was said that *"misconduct can also include incompetence or negligence of a high degree (para.36) … mere negligence does not constitute misconduct. A single act or omission is less likely to cross the threshold of misconduct than acts or omissions. Nevertheless and depending on the circumstances, negligent acts or omissions which are particularly serious may amount to misconduct".*

He therefore directed it was for the panel to determine whether that threshold had been crossed.

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

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

Decision and reasons on misconduct

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

The panel was of the view that Mrs Parr’s actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Parr’s actions amounted to multiple breaches of the Code. Specifically:

> ***1 Treat people as individuals and uphold their dignity***
>
> > *To achieve this, you must:*
> >
> > *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***3 Make sure that people’s physical, social and psychological needs are assessed and responded to***
>
> > *To achieve this, you must:*
> >
> > *3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages*
> >
> > *3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*
>
> ***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*

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including

information relating to using any health and care products or services

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

8 Work co-operatively

To achieve this, you must:

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

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

8.6 share information to identify and reduce risk

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

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

10.1 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

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

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

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

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:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.4 take all steps to keep medicines stored securely

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

To achieve this, you must:

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

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

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

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

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

To achieve this, you must:

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

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

The panel acknowledged that breaches of the Code do not automatically result in a finding of misconduct. It considered that some of the charges it found proved, in isolation, would not be sufficient to amount to misconduct. However, cumulatively, the panel considered the issues to cross the threshold for misconduct. Furthermore, some of the concerns, especially those raising risks of harm to service users, such as safe use of medication and equipment, were of themselves sufficiently serious to amount to misconduct.

The panel was of the view that the issues in this case are varied, wide ranging, and persistent over time. The panel bore in mind that Mrs Parr failed to establish and undertake an effective drug audit process. It appeared to the panel that Mrs Parr permitted standards at the home to fall to an unacceptable level, despite clear warnings from the first CQC report that the service required improvement, including on safety.

Residents, and their families, were relying on the Home to administer their medication and provide safe and effective care. Particularly shocking to the panel was the evidence before it that residents with serious health conditions went days without receiving their medication. Mrs Parr was made aware of the areas which needed improvement within the CQC's first report dated 31 October 2018. By the time of the CQC's second inspection, 3 months later, the quality of service had deteriorated to such an extent that the CQC issued a formal notice to cancel Mrs Parr's registration as a registered manager. The Home was

subsequently closed down. The panel considered Mrs Parr to have had opportunity enough to make the improvements suggested to her by CQC, but she failed to take any action at all.

Given the varied, wide ranging, persistent and serious issues in this case, which put residents at risk of harm, the panel reached the view that Mrs Parr's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Parr'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 responsible and professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. Nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

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

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

d) …

The panel found that residents were put at serious and continued risk of harm as a result of Mrs Parr's misconduct. Mrs Parr's misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel took account of the certificates Mrs Parr provided on safe administration of medication, safeguarding of vulnerable adults, medicines use in care homes, sharps awareness, infection control, and stress management, all dated 2018/2019. There was no evidence before the panel, however, of any learning or remediation within the past two years.

The panel also noted that although Mrs Parr has acknowledged some of her failings and demonstrated limited insight, there was nothing before the panel to indicate that Mrs Parr had any insight into the serious risk of harm to residents caused by her misconduct, or the impact of her misconduct upon the reputation of the nursing profession.

The panel acknowledged the personal challenges that Mrs Parr was experiencing at the time. However, Mrs Parr was the registered manager of the Home and it was her responsibility to ensure that the care provided was safe and effective. Overall responsibility

rested with Mrs Parr, and she failed to ensure that residents were properly cared for despite being provided with clear direction about the areas for improvement by the CQC.

Had Mrs Parr acted upon the recommendations made by the CQC in its report dated 31 October 2018 then the quality of service provided may not have deteriorated to the point that it was necessary to cancel her registration as manager. Mrs Parr failed to take any action at all in response to the CQC's recommendations, and allowed systemic failures to persist, which the panel considered to indicate a serious and harmful attitudinal issue, particularly in a position of authority and with the responsibilities of Home manager.

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

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel considered Mrs Parr's failure to act upon the CQC's recommendations in its October 2018 inspection report increased the public interest aspect of this case. CQC inspections play a vital role in maintaining safe standards of healthcare delivery. It is incumbent on healthcare professionals, particularly with managerial responsibility, to act urgently in response to inspection reports identifying areas requiring improvement, especially in respect of patient safety. A failure to do so risks seriously undermining the public's confidence in the regulatory systems put in place to protect patients. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr's Parr's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Parr's name from the register. The effect of this order is that the NMC register will show that Mrs Parr's name has been struck from the register.

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

Decision and reasons on sanction

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

The panel noted the NMC's submission that six month suspension order would be appropriate to address the sanction in this case.

The panel took into account the following aggravating features:

- Mrs Parr's limited insight into her failings;
- The numerous and very varied issues over a prolonged and extended period of time;
- That residents were put at serious risk of physical harm and in some cases were harmed;
- Mrs Parr's failure to respond to the recommendations made by the CQC in its report following inspection in August 2018, which the panel considered to be an indication of an attitudinal problem.

The panel also took into account the following mitigating features:

- Mrs Parr accepted the concerns relating to catheterisation of Resident A and medication safety;
- Mrs Parr was experiencing personal challenges at the time;
- No previous regulatory concerns during a lengthy nursing career.

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

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

The panel next considered whether placing conditions of practice on Mrs Parr's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the range and nature of the issues in this case. In addition, the panel decided that a conditions of practice order would not address the attitudinal concerns. Furthermore, the panel concluded that the placing of conditions on Mrs Parr's registration would not adequately reflect the seriousness of this case and would not protect the public or be sufficient to uphold confidence in the profession. The panel noted that Mrs Parr in her responses has expressed a firm intention to retire from nursing and consequently such an order would not be workable.

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

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breaches of the fundamental tenets of the profession evidenced by Mrs Parr's actions were such that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Mrs Parr's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel identified in particular in reaching this decision:

- These were multiple incidents of misconduct which would not be addressed by a lesser sanction
- The panel found that there was evidence of an attitudinal problem particularly in relation to the reports and involvement of the CQC
- There was evidence of a repetition of the misconduct after the first visit and report of the CQC

- The panel found that Mrs Parr had shown only very limited insight and was of the view that there was a significant risk of her repeating her behaviour

The panel was of the view that the findings in this particular case demonstrate that Mrs Parr's actions were serious and to allow her to remain on the register would undermine public confidence in the profession and in the NMC as a regulatory body.

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

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

This will be confirmed to Mrs Parr in writing.

Interim order

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

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

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

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

That concludes this determination.