Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 7 March - Tuesday 22 March 2022
Wednesday 13 July – Tuesday 19 July 2022

Virtual Hearing

Name of registrant:	**Damien Bernard Hunt**
NMC PIN:	00C0445E
Part(s) of the register:	Registered Nurse – Adult Nursing (March 2003)
Area of registered address:	Redcar
Type of case:	Misconduct
Panel members:	Patricia Richardson (Chair, Lay member) Mark Gibson (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	John Bassett
Hearings Coordinator:	Alice Byron (Monday 7 March - Tuesday 22 March 2022) Opeyemi Lawal (Wednesday 13 July – Tuesday 19 July 2022)
Nursing and Midwifery Council:	Represented by Sophie Quinton-Carter, Case Presenter
Mr Hunt:	Present and represented by Jim Olphert, Counsel instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	Charge 6
Facts proved:	Charge 1 in its entirety, 2c, 2d, 2e, 4a, 4d, 4e, 4f, 4g, 5a, 5b, 5c, 5d, 5e, 7, 9, 10a, 10b, 11, 12, 13, 14
Facts not proved:	2a, 2b, Charge 3 in its entirety, 4b, 4c, 8,
Fitness to practise:	Impaired

Sanction:	Striking off order
Interim order:	Interim suspension order (18 months)

Details of charge (as amended)

That you, a registered nurse, whilst employed at Lifestyle Abbey Care (known as 'Archery Bower') Care Home (hereafter referred to as 'the Home')

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    a. discrepancies in the Controlled Drug Log for the amount of medication held at the home, attributed to/for Service User J; **[PROVED]**

    b. discrepancies between the Controlled Drug Log and the MAR Chart pertaining to medication administered Service User J; **[PROVED]**

    c. evidence of administration of medication to Service User J otherwise than in accordance with their prescription; **[PROVED]**

    d. unclear records pertaining to authorisation of a change of prescription for medication for Service User J; **[PROVED]**

    e. you did not arrange training for care assistants in respect of being the second signatory for medication administrations; **[PROVED]**

    f. unclear or no records pertaining to authorisation of a change of prescription for medication for Service User F; **[PROVED]**

    g. all prescribed medication was not administered to Service User P on 28 October 2016; **[PROVED]**

    h. no record in the notes of the site of application of Service User S's transdermal patch; **[PROVED]**

    i. no MAR Chart available for Service User A; **[PROVED]**

j. medication was administered covertly to Service User B and/or Q and/or K without proper consideration of issues of consent and/or proper assessment and/or proper form of authorisation; **[PROVED]**

k. body maps and / or administration records had not been completed for one or more service users prescribed creams / ointments / lotions; **[PROVED]**

2. Did not ensure that there were adequate processes in place and/or being followed in relation to assessments and / or care planning as demonstrated by:

a. on 02 November 2016, you were unaware of Service User A residing at the Home; **[NOT PROVED]**

b. no prescribed medication was administered to Service User H, a new resident, between 22 October 2016 and 25 October 2016; **[NOT PROVED]**

c. By 25 October 2016, for Service User Q, a new resident admitted on 21 October 2016, no care records or daily notes existed **[PROVED]**

d. The care planning documents subsequently created for Service User Q were generic and not adequately updated **[PROVED]**

e. One or more care plans **[PROVED]**

i. were not clinical in nature and/or
ii. did not reflect specific care and/or nursing needs and/or
iii. were generic/not completed accurately.

3. Did not ensure that there were adequate processes in place and/or being followed in relation to weight management as demonstrated by:

a. weight records only being available for residents on the upstairs unit; **[NOT PROVED]**

b. weight records were not up to date and/or completed in a timely manner; **[NOT PROVED]**

c. no evidence of action taken when records available demonstrated that residents have lost weight; **[NOT PROVED]**

d. The completion of Service User P's MUST tool was incorrect. **[NOT PROVED]**

4. Did not ensure that the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

a. there was no evidence of references checked for Nurse A; **[PROVED]**

b. there was no evidence of Disclosure and Barring checks for Nurse A; **[NOT PROVED]**

c. there was no evidence of risk assessment around Person B's suitability to be involved in the administration of medication; **[NOT PROVED]**

d. checks on the validity of information provided by recruitment agencies were not carried out; **[PROVED]**

e. checks on the validity of information provided by nurses about their NMC registration were not carried out; **[PROVED]**

f. you did not carry out an adequate assessment of the suitability of Person C's position at the Home given his fitness to practise history; **[PROVED]**

g. you did not carry out an assessment of the suitability of Person A for her position in light of her criminal conviction; **[PROVED]**

5. Did not ensure that the systems in place and/or being followed for managing staff were appropriate as demonstrated by:

   a. permitting/allowing non-nurse staff to write care plans; **[PROVED]**

   b. staff members were not consistently signing in for shifts; **[PROVED]**

   c. staff sign-in times were not always accurate to the time that staff were on site; **[PROVED]**

   d. you did not have sufficient oversight of staff who were working at the Home; **[PROVED]**

   e. you did not ensure that staff were working safe hours. **[PROVED]**

6. Did not promptly investigate concerns relating to discrepancies in medication administration at the Home, brought to your attention during the CQC investigation on 25 October 2016. **[PROVED BY ADMISSION]**

7. Did not promptly take action to ensure that staff sign in records were accurate at the Home, after it was brought to your attention during the CQC investigation on 25 October 2016. **[PROVED]**

8. Allowed/permitted one or more residents to be admitted to the Home after being asked not to do so by the Care Quality Commission or agreeing that you would not do so. **[NOT PROVED]**

9. After 04 November 2016 did not provide an adequate and/or timely action plan for the Home, addressing all the concerns brought to your attention by the CQC. **[PROVED]**

10. Permitted/Allowed Nurse A to work at the Home in breach of an interim conditions of practice order as follows;

    a. when there was not adequate supervision for her as directed by condition 1; **[PROVED]**

    b. when she was not adequately assessed as competent to administer medications as directed by condition 2. **[PROVED]**

11. Created a risk assessment document pertaining to Nurse A's employment at the Home, dated 31 September 2016, which was false because you had not formally considered the risks of Nurse A's employment at the Home as set out in the document. **[PROVED]**

12. Your conduct in Charge 11 above was dishonest because you thereby created a false record pertaining to your management of the employment of Nurse A at the Home. **[PROVED]**

13. On 25 October 2016 presented the risk assessment document, dated 31 September 2016, to the CQC inspector as evidence that you had considered the

risks of Nurse A's employment at the Home as set out in the document, when you had not. **[PROVED]**

14. Your conduct at Charge 13 above was dishonest as you presented the document in order to create a more favourable impression of your management of Nurse A to the CQC. **[PROVED]**

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Quinton-Carter, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charges 4c, 4f and 12.

In respect of charge 4, the amendment proposed was to change reference to 'Carer B' to 'Person B' in charge 4c, and to amend the reference to 'Nurse C' to 'Person C' in charge 4f. It was submitted by Ms Quinton-Carter that the proposed amendment would provide clarity and more accurately reflect the evidence, notably the witness statement provided by Witness 1.

4. Did not ensure that the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

[…]

c. there was no evidence of risk assessment around ~~Carer B's~~ **Person B's** suitability to be involved in the administration of medication;

[…]

f. you did not carry out an adequate assessment of the suitability of ~~Nurse C's~~ **Person C's** position at the Home given his fitness to practise history;

[…]

In respect of charge 12, the proposed amendment was to change the word 'you' at the start of the charge, to 'your'. It was submitted by Ms Quinton-Carter that the proposed amendment would correct a grammatical error contained within the charge.

12. Yo**ur** conduct in Charge 11 above was dishonest because you thereby created a false record pertaining to your management of the employment of Nurse A at the Home

Mr Olphert, on your behalf, indicated that he supported the proposed amendments.

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 amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

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

In the course of Witness 1's evidence, Mr Olphert made a request that this case be held in private on the basis that proper exploration of your case involves reference to your health

and personal circumstances. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Quinton-Carter indicated that she supported the application to the extent that any reference to your health and personal circumstances should be heard in private.

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

The panel determined to go into private session in connection with your health and personal circumstances as and when such issues are raised.

Decision and reasons on application for you to turn off your camera and distance yourself from the screen during the course of the hearing

In the course of witness evidence, Mr Olphert made an application that you be permitted to turn your camera off, or step away from the screen, as required. [PRIVATE]

Ms Quinton-Carter did not make any submissions on this application.

The panel accepted the advice of the legal assessor.

The panel accepted the application and determined that you be permitted to turn off your camera and/or distance yourself from your screen during the course of the hearing. The panel concluded that this solution would not result in any unfairness to either party. It noted that you are represented, and therefore the risk that you may not hear the full case against you is safeguarded by your ability to speak to Mr Olphert in conference. The panel further noted that Mr Olphert's proposal would likely avoid further delays in the course of the hearing.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Olphert who informed the panel that you made full admissions to charge 6.

The panel therefore finds charge 6 proved, by way of your admissions.

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

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

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

- Witness 1: Care Quality Commission (CQC)
  Inspector at the time of the charges.

The panel also heard evidence from you under affirmation.

The panel received witness statements from Dr 1 and Person D, on your behalf, and Ms 4, on behalf of the NMC.

Background

The charges arose whilst you were employed in a managerial role by Lifestyle Abbey Care Limited. Throughout the relevant period you were a registered nurse.

On 25 October 2016, the CQC conducted an unannounced inspection of the Home, at the time of this inspection you were the “nominated individual” and were regarded by the CQC as the Acting Manager of the Home. Following this inspection, it is alleged that the CQC requested that you undertake improvement steps. On 28 October 2016, the CQC issued a voluntary undertakings letter requesting an agreement that no further service users be admitted to the Home. It is alleged that this was returned to the CQC, signed by you, on 1 November 2016. It is further alleged that new service users were admitted to the Home on 31 October 2016 and 1 November 2016.

On 2 November 2016, a second inspection was carried out by the CQC. It is alleged that the CQC Inspectors determined that you had failed to take action in respect of the improvement steps identified on 25 October 2016. The CQC inspections purported to identify inadequate procedures in relation to medications management/administration, inadequate processes in relation to assessments and/or care planning of residents, inadequate processes in relation to weight management, inappropriate systems in regard to staff recruitment and management, and inadequate measures in place to ensure staff signing in records were accurate. It also appeared that a nurse was being allowed to work at the Home in breach of an interim conditions of practice order imposed upon her.

On 4 November 2016, the CQC issued a Letter of Intent to use Section 31 powers. You provided an action plan setting out proposed steps to resolve the concerns raised in the inspections in response to this letter. This plan was deemed unsatisfactory by the CQC and you submitted a revised action plan on 14 November 2016. It is alleged that the CQC remained concerned about the inadequacy of the revised action plan.

On 11 November 2016, the CQC imposed a condition that the Home not admit new service users without prior written agreement of the CQC.

On 17 November 2016, the CQC issued a Section 31 Notice imposing improvement conditions upon the registered provider, your employer.

The CQC subsequently made a referral concerning your fitness to practise as a nurse to the NMC.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Olphert that there is no case to answer in respect of charges 4b, 4c, 8, 10 in its entirety, 11, 12, 13 and 14. This application was made under Rule 24(7).

In relation to charge 4b, Mr Olphert submitted that, the documents available to the panel shows that Nurse A's personnel file contained a Disclosure and Barring Service (DBS) certificate dated 8 January 2016. He therefore submitted that the document demonstrates that there was evidence of DBS checks having been undertaken, and provided to Abbey Care. He told the panel that the evidence to support this charge is therefore inconsistent and tenuous and the charge as a result ought properly to be dismissed.

He outlined for the panel that, as with other allegations in respect of staff records, Witness 1's comment that the CQC would not have issued findings on this in light of the present documents demonstrates the allegation to be tenuous or inconsistent. In these circumstances, it was submitted that this charge should not be allowed to remain before the panel.

In relation to charge 4c, Mr Olphert submitted that you have provided for the panel documents pertaining to Person B's suitability regarding medication. He said that the charge avers that there was no evidence of such documentation. He submitted that the documents demonstrate that there was evidence of such an assessment, as demonstrated by documents which spoke to Person B's qualification certificates.

In light of this, he submitted that there is sufficient evidence to render the evidence provided by the NMC tenuous or inconsistent.

He submitted that, as with other allegations in respect of staff records, Witness 1's comment that the CQC would not have issued findings on this in light of the present documents demonstrates the allegation to be tenuous or inconsistent. In these circumstances, it was submitted that this charge should not be allowed to remain before the panel.

In relation to charge 8, Mr Olphert submitted that that the charge as drafted is insufficiently precise, and in any event not made out.

He said that it is clear from the evidence of Witness 1 that the requirement not to admit any new patients came into effect from the time of the document being signed, being 1 November 2016. He reminded the panel that Witness 1's evidence was that she might have expected you or others to stop admitting when the notice was served, and that the Home could have raised any pre-agreed admissions with the CQC.

Mr Olphert submitted that you could not be expected to know that there was an expectation not to admit after receiving the letter, which does not make reference to this requirement. He told the panel that there is evidence before it to show that the patients were admitted to the Home on 27 October 2016 and 31 October 2016. He submitted that the suggestion by Witness 1 that you bore a moral obligation not to admit patients is tenuous and inconsistent. In these circumstances, it was submitted that this charge should not be allowed to remain before the panel.

In relation to charge 10a, Mr Olphert told the panel that charge as drafted asks a binary question, was the supervision adequate and in compliance with condition 1 of Nurse A's conditions of practice order. He told the panel that, although Witness 1 stated that the supervision in place was inadequate, the annotated conditions of practice document which

you provided to the panel demonstrates that the NMC were satisfied with the arrangements in place.

Mr Olphert submitted that it is a judgment call for the NMC and not Witness 1 as to whether sufficient supervision was in place. Further, the allegation does not aver that any call should have been made before November, it simply says that there were actions taken not in compliance with the conditions. The annotation demonstrates that the approach was consistent.

It may be said by the NMC that Witness 1's evidence was that on one occasion Nurse B appeared to be unaware of the need to reside at the home. It is submitted that this does not alter the position in respect of any burden which Mr Hunt may have borne as manager.

As a result of the annotation, the evidence is, at its best, insufficient and the charge could not be made out.

In relation to charge 10b, Mr Olphert submitted that it is clear on the face of the documents which you have provided that Nurse A was adequately assessed in this regard. He submitted that the allegation can only be proven if the panel are capable of being satisfied that Nurse A was working whilst not assessed as competent. He referred the panel to Nurse A's personnel file and said that this demonstrates that assessments were undertaken regarding her medicine competencies on 19 July 2016 and 24 October 2016, the latter date being one day prior to the initial CQC inspection. He further submitted that at least one of the review documents, being the record dated 19 July 2016, appears to have been in the NMC's possession at the time of charge and so the allegation is patently undermined by both documents in their possession and subsequent evidence provided.

Mr Olphert told the panel that any evidence to support the allegation is now so tenuous that no panel properly directed as to the law could properly conclude the fact was proven. In these circumstances, it was submitted that this charge should not be allowed to remain before the panel.

Mr Olphert told the panel that charges 11, 12, 13 and 14 are related and therefore addressed these charges together. He submitted that it is a central part of the allegations that form the basis for both charge 11 and charge 13 that the document produced was false documentation because risk assessments had not been conducted. He submitted that it was clear that such risk assessments had been conducted. He told the panel that Witness 1 accepted that the new documents which you provided in the course of this hearing would likely have led the CQC to reconsider the findings in respect of adequate staffing concerns.

Further, he submitted that the risk assessments and medication management plans on file demonstrate incontrovertibly that the document was not false on the basis that there had been a failure to complete the assessment or consider the risk. On that basis charge 11 and charge 13 must both fail in respect of the second element of the charge. He told the panel that this is evidenced by the risk assessment and management plan contained within Nurse A's personnel file documents which demonstrate that a little over a month prior to the inspection you had assessed the risk in respect of Nurse A, and that there was a plan for managing that risk in place.

Mr Olphert therefore submitted that it necessarily follows that there can be no finding of dishonesty, as alleged in charges 12 and 14. He said that, even were the panel to conclude that charges 11 or 13 were made out in that the record was false, it could not have been dishonest because it was reflective of a properly conducted assessment. He told the panel that the record was not false and, in any event, there is no prospect that the test set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67 could apply in these circumstances. Mr Olphert submitted that charges 11 – 14, or at minimum charges 12 and 14 which relate to dishonesty should be properly dismissed. In these circumstances, it was submitted that these charges should not be allowed to remain before the panel.

Ms Quinton-Carter submitted that you have provided the panel with a significant amount of documentation in the process of this hearing, much of which is relied on in support of your

submissions of no case to answer. The documents are not formally in evidence at this stage as they have not been admitted by the NMC. She said that this documentation was not previously available to the CQC. She reminded the panel of Witness 1's evidence, that the CQC provided you with numerous opportunities to provide documents and correct inaccuracies in their findings, which were not taken advantage of. She further told the panel that these documents were not located by the CQC, despite thorough checks, during the inspections. In light of this, she told the panel that that the current status or provenance of these documents is unclear and should be properly tested by the NMC during your evidence.

In respect of charge 4b, Ms Quinton-Carter reminded the panel that the charge reads "there was no evidence of Disclosure and Barring checks for Nurse A". She said that Witness 1 confirmed that the DBS Certificate, dated 8 January 2016, was not present on file at the time of the CQC inspection. Ms Quinton-Carter told the panel that Witness 1 further confirmed that the manager would be accountable for the people employed and ensuring the recruitment practice is being adopted. She said here was nothing in Nurse A's file to confirm the checks had been made at the time of the inspection.

Ms Quinton-Carter submitted that any new document provided during the course of the hearing is untested evidence and should not result in the end of this charge at this stage.

She said that there is no evidence as to the provenance of the DBS certificate, or whether it is asserted that this document was present at the time. Further she submitted that there is presently no evidence that you were aware of this document at the time of the inspection, or your involvement in its retention or storage. She told the panel that, given that you only provided the DBS certificate during the course of the hearing, it remains the NMC's case that there was no evidence of this document at the time you were responsible for the Home. Ms Quinton-Carter therefore submitted that there remains a case to answer in respect of this charge and the document relied upon.

In respect of charge 4c, Ms Quinton-Carter reminded the panel that the charge is not that there was no evidence of Person B's suitability to administer medication, but that there was no risk assessment conducted regarding this. She told the panel that in Witness 1's evidence, she explained that there was no evidence of such risk assessment and no exploration as to why Person B ceased to be a nurse, which she said was particularly important as he was administering medication. Witness 1 further stated that no evidence of medication training was provided to the CQC. Ms Quinton-Carter accepted that, in the documents provided by you, there is an indication that someone considered this issue, however it is not clear who this was, or when this took place, except that the first certificate is dated July 2016.

Ms Quinton-Carter submitted that the NMC's case is that you did not do a risk assessment and you did not have oversight. She said that the only person who can speak to whether this risk assessment was in fact done is you. She said that is not sufficient to provide documents such as training certificates to satisfy this charge as such certificates do not indicate your awareness or involvement in the assessing Person B's suitability to be involved in the administration of medication, which she submitted, as the individual in charge at the Home, you were responsible for. In light of this, Ms Quinton-Carter submitted there remains a case to answer in respect of charge 4c.

In relation to charge 8, Ms Quinton-Carter accepted that the undertaking to admit new residents to the home was not agreed until 1 November 2016. However, she told the panel that Witness 1's evidence was that the safety of the Home was raised in feedback following the first inspection on 25 October 2016, during which time she said that you were present and put on notice that new residents should not be admitted. Ms Quinton-Carter reminded the panel that, during her evidence, Witness 1 suggested that if there were staffing or financial constraints on the Home, this would be a further reason not to admit new residents.

Ms Quinton-Carter further invited the panel to consider the email from the Director of the Home which shows that the proposed undertaking was received on 28 October 2016. This

email is contained within the bundle which you provided to the panel. In these circumstances, Ms Quinton-Carter submitted that it cannot be said that you were not aware of the request not to admit further residents.

Ms Quinton-Carter said that the evidence of Witness 1 was clear that you could give no explanation as to why new residents were admitted to the Home. She noted that it is now suggested that these were pre-booked transfers. She outlined that this suggestion was not made to the CQC at the time of inspection. Ms Quinton-Carter said that only you can provide evidence on the status of the admissions, as there is no documentary evidence to support it. In these circumstances, Ms Quinton Carter submitted that there remains a case to answer.

In relation to charge 10b, Ms Quinton-Carter asked the panel to consider the evidence of Witness 1, that there was no other nurse on shift when she arrived at the Home on 25 October 2016 and was greeted by Nurse A. From Witness 1's evidence, Ms Quinton-Carter submitted that it appeared that Nurse A lied about the presence of another nurse on the shift, and that you thought that under any other circumstance, a nurse sleeping whilst Nurse A was on duty would be sufficient to meet the conditions of practice order requirements.

Ms Quinton-Carter noted the annotated conditions of practice document contained within Nurse A's personnel file and submitted that the annotation by your predecessor at the home shows that in a short space of time, she was clearly managing Nurse A's requirements as outlined in the conditions of practice order. She submitted that the same could not be said of your management of Nurse A's requirement.

Ms Quinton-Carter referred the panel to the subsequent annotation on the document and made the following submissions:

1. The annotation is dated 10 November 2016, which was long after the CQC's first inspection and after adequate supervision should have been in place.

2. The end of the annotation is unclear.
3. You seek to rely on untested hearsay within the document. Only you can speak to the conversation noted, if it was you who made this note.

Further, Ms Quinton-Carter told the panel that Nurse A admitted to working in breach of the conditions of practice order on her registration. In light of the above, she submitted that there is clearly a case to answer in respect of this charge.

In respect of charge 10b, Ms Quinton-Carter told the panel that the assessment document dated 24 October 2016, which you provided for this hearing, is not an agreed document. She said it is disputed and has not been tested as to provenance or content. Ms Quinton-Carter submitted that the panel should place no weight on this document until it has been tested in your evidence. Further, she said that there are clear questions over this document, not least because the 27 October 2016, being the day after the first inspection, appears to have been written on the document and then amended to 24 October 2016. Further, she submitted that the document was not provided to or located by the CQC. Ms Quinton-Carter said that it had been so recently created, it should have been present or easily located during the inspection. She submitted that this clearly gives rise to a case to answer.

Further, Ms Quinton-Carter submitted that, at a hearing on 6 March 2019, Nurse A admitted to breaching her conditions of practice on 25 October 2016 and 2 November 2016. She further invited the panel to consider the bundle which you provided for this hearing, in which you state “this shouldn’t have happened” in relation to this concern. Ms Quinton-Carter submitted that this suggests an admission to permitting Nurse A to work in contravention of her conditions of practice order.

Further, Ms Quinton-Carter submitted that the assessment completed by Mr 2 on 19 July 2016 remains to be tested in evidence. She said that only you can speak to Mr 2’s role, the purpose of that assessment, and whether Mr 2 was clinically qualified to complete it.

Further, she submitted that if this assessment existed and you were aware of it, there would have been no need for a further assessment to have been taken in October 2016. She said that the October 2016 assessment does not replicate the one in July 2016. She highlighted that this, this document was not located by, or provided to, the CQC.

Ms Quinton-Carter submitted that this charge relates to your responsibility, she said that there is no evidence that you considered the risks presented by Nurse A. She said that you had overall responsibility for the Home and permitted or allowed Nurse A to work in breach of her conditions of practice order, therefore there remains a case to answer in respect of this charge.

In relation to charges 11, 12, 13 and 14, Ms Quinton-Carter said that the risk assessment within Nurse A's file which you provided is not accepted by the NMC. Further, she said that it only speaks to issues concerning Nurse A's health and risks arising from this and does not deal with any other risks, namely the conditions of practice order. She submitted that simply providing a further risk assessment is not sufficient to address these charges.

Ms Quinton-Carter submitted that only the risk assessment dated 31 September 2016 speaks to any risk associated with Nurse A's conditions of practice order. She said that the legitimacy of this document is challenged as the date provided does not exist. Further, she submitted that there is no evidence to show the risks considered in this document had previously been considered by you.

Ms Quinton-Carter said that it is the NMC's case that the risks associated with Nurse A's conditions of practice order had not been considered previously by you and this document was created and subsequently presented to the CQC in order to suggest that they had. She further submitted that to do so amounted to dishonest conduct on your part.

Ms Quinton-Carter submitted that, in not yet explaining to the panel the origin, or reason for the assessment created in September 2016, there remains a case to answer in respect of charges 11, 12, 13 and 14.

At the conclusion of their submissions Ms Quinton-Carter and Mr Olphert agreed that, if the panel is to find a case to answer in respect of any of the charges, it will adopt the procedures of the Crown Court and other regulatory jurisdictions, and will not be required to provide reasons for finding a case to answer in respect of any charge.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage, the panel reminded itself that you are still to give evidence and noted that a finding of a case to answer in respect of any charge is not an indication of a finding of fact. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer in relation to the charges outlined by Mr Olphert.

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Panel Decision and Reason on Facts

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

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

Charge 1

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

The panel first considered the stem of this charge in relation to the role which you held at the Home and whether this role created a duty for you to ensure that there were adequate processes/procedures in place and/or being following in areas specified in charge 1. In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1, the witness statements of Dr 1 and Person D, and your evidence.

The panel first considered the roles and responsibilities which you held in the Home. It heard the NMC's position, that you were the manager of the Home, and held responsibility for the day-to-day running of the home, including the duties specified in charge 1. The panel heard your evidence that, although you were the nominated individual at the Home, this was an administrative title which you had been pressured into taking by the Directors of the Home. You said that you were the Area Manager for the home and that your responsibilities in relation to the Home were limited in the time leading up to the CQC inspection in October 2016. The panel also heard from Witness 1. The panel found this witness's oral evidence to be credible and consistent with her witness statement, in respect of your role and responsibilities at the Home at the time of the inspection.

The panel considered your role as Area Manager at Lifestyle Abbey Care. It noted your witness statement in which you stated that: "I was never given any contract of employment or job description nor any form of formality in connection with my appointment". The panel therefore concluded that, in the absence of such job description, there was no information before the panel to specify the individual responsibilities of your role as Area Manager, and could not exclude the responsibilities specified at charge 1.

You gave evidence to the panel that you are an experienced Area Manager and that you worked primarily within the Home for the first year of your employment, from around August 2014, as the Home was in special measures at the time. You accepted that there was not a registered manager in place at the Home at the time of the CQC inspection, nor had there been a registered manager in place at the Home for a period of approximately five years, with the exception of a period of five days between 3 and 7 October 2016, when Ms 3 was working as a manager at the Home. The panel concluded that, on the balance of probabilities, you held the role of the manager of the Home during the initial period from August 2014, which included the responsibilities specified at charge 1.

The panel went on to consider your responsibilities in relation to the Home at the time of the CQC inspection. The panel heard your evidence that, as Area Manager, you had responsibility for five care homes. It noted your witness statement, in which you stated: "prior to the CQC inspection in October and November 2016, I had not been at the Home for three months as I was tending to the other care homes I oversaw". The panel found this account to be inconsistent with your oral evidence, during which you said that you attended the Home more frequently, and up to twice a week, during the same period in 2016. The panel concluded that this suggests that you had more involvement in the management of the Home than you initially disclosed. The panel took account of the documentary evidence before it, including information which had been provided by the NMC and documents which you had provided including performance reviews of staff members, competency reviews which you carried out with nurses, and an email, dated 22 October 2015, to nurses at the Home in which you set out the duties and expectations of the Home in relation to medicines management. The panel concluded that this information demonstrates that you took responsibility for the management of the Home during the relevant period.

The panel next looked at the evidence of Witness 1, Dr 1 and Person D. It noted that it is agreed by parties that you were the nominated individual in respect of the Home, although you deny that you were the manager of the Home at the time of the CQC inspection. It took into account Witness 1's witness statement in which she stated:

"During the inspections of 25 October 2016, 2 November 2016 and 28 November 2016, nothing was found in writing to say Damian Hunt was the Home Manager, although we knew he was the 'nominated individual' and that he was overseeing the service and was employed within this capacity. Some of the healthcare assistants told me that they considered Damian Hunt to be the manager of the home because he sat in the manager's office."

The panel found Witness 1's oral evidence to be consistent with her witness statement in respect of this matter.

The panel took account of the witness statement of Person D, in which she states: *'I think Damian was the manager of the Home, before going on to become the Area Manager.',* and subsequently: *'Damian was the manager on the side I worked at, Mr 2 was the manager on the other side.'.* The panel concluded that these statements demonstrated that, on the balance of probabilities, Person D regarded you as the manager of the Home.

The panel accepted the witness statement of Dr 1, in which he states: *'I know Damien Hunt personally as the manager of the unit at Abbey Care'.* The panel concluded that this statement demonstrated that, on the balance of probabilities, Dr 1 regarded you as the manager of the Home.

The panel noted that charge 1 does not refer to your duties as the manager of the Home, but those implied by being the person of responsibility at the Home. In all the circumstances, the panel was satisfied that, in the absence of a registered manager you were the most senior manager with the day to day responsibility of the Home.

The panel concluded that you had been appointed with primary responsibility of the Home in August 2014 when it was placed in special measures. From your oral evidence, the panel determined that, as the Home improved, your remit as Area Manager grew to include responsibilities at further care homes owned by Lifestyle Abbey Care Limited.

However you continued to have management responsibilities for the Home, and therefore had the overall responsibility for the Home, including those which related to the relevant processes, policies and procedures at the Home.

Accordingly, the panel determined that, on the balance of probabilities, you had a duty to ensure that there were adequate processes/procedures in place and/or being following in areas specified in charge 1.

Charge 1a.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    a. discrepancies in the Controlled Drug Log for the amount of medication held at the home, attributed to/for Service User J;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel considered that the evidence before it suggests that you accept that the discrepancies alleged within charge 1a existed at the Home. The panel noted Mr Olphert's written submissions as to facts, which sets out: *'it is clear that Mr Hunt admits there were issues with controlled drug management.'.*

The panel had regard to the incident investigation report, dated 7 November 2016, in which you outlined that you had found a total of 15 errors relating to the Controlled Drug Log for Service User J. The panel noted your findings in this report, including action taken, including *'the medication is being audited weekly and monthly'*. The panel also had sight of the Controlled Drug Log for Service User J.

The panel further noted an email, dated 22 October 2015, to nurses at the Home in which you set out the duties and expectations of the Home in relation to medicines management. However, it bore in mind that this document was not provided to the CQC at the time of its inspection in October and November 2016. You said that the processes and procedures in respect of controlled drug management were in place at the relevant time, and that, as Area Manager, it was not your role to ensure that the procedures were being followed by nursing staff at the Home, as you were not on site at all times to ensure compliance.

The panel noted that Witness 1's evidence in respect of charge 1a was based upon the information which she received from a pharmacist colleague at the CQC during the time of the inspection. The panel recognised that this evidence was hearsay, however the panel found Witness 1's evidence in respect of this matter to be clear, credible and consistent with the information provided in her witness statement.

The panel accepted that there is evidence before it that processes were implemented in 2015 as a result of the email dated 22 October 2015, and 'action taken' was outlined in the investigation report on 7 November 2016. The panel accepted your evidence that the home manager should have been undertaking weekly audits of controlled drugs, and that you, as area manager, should have been undertaking quarterly audits. However, there was no evidence before the panel that you had carried out these, or any, audits, or taken any further action, to ensure that the processes implemented followed in relation to medications management and/or medications administration were being followed effectively by staff at the Home.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1a is proved.

The panel therefore found this charge proved.

Charge 1b.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    b. discrepancies between the Controlled Drug Log and the MAR Chart pertaining to medication administered Service User J;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel considered that the evidence before it suggests that you accept that the discrepancies alleged within charge 1b existed at the Home. The panel noted Mr Olphert written submissions as to facts, which set out: *'it is clear that Mr Hunt admits there were issues with controlled drug management.'.*

The panel had regard to the incident investigation report, dated 7 November 2016, in which you outlined that you had found a total of 15 errors relating to the Controlled Drug Log for Service User J. The panel noted your findings in this report, including action taken, including *'the medication is being audited weekly and monthly'*. The panel also had sight of the Controlled Drug Log for Service User J, and the associated MAR Charts for Service User J.

The panel further noted an email, dated 22 October 2015, to nurses at the Home in which you set out the duties and expectations of the Home in relation to medicines management. However, it bore in mind that this document was not provided to the CQC at the time of its inspection in October and November 2016. You said that the processes and procedures in

respect of controlled drug management were in place at the relevant time, and that, as Area Manager, it was not your role to ensure that the procedures were being followed by nursing staff at the Home, as you were not on site at all times to ensure compliance.

The panel noted that Witness 1's evidence in respect of charge 1b was based upon the information which she received from a pharmacist colleague at the CQC during the time of the inspection. The panel noted the various examples of the discrepancies between the Controlled Drug Log and MAR Charts in respect of Service User J set out in Witness 1's witness statement, and concluded that they are wide ranging and relate to discrepancies in the quantity of medication in the Home stock, the time of administration of the medication, the dosage received by Service User J, and failure to evidence who had authorised a change in Service User J's prescription. The panel recognised that this evidence was hearsay, however the panel found Witness 1 could clearly recall the conversations which she had with her pharmacist colleague, and her colleague's findings in respect of this charge. Accordingly, the panel found Witness 1's oral evidence in respect of this matter to be clear, credible and consistent with the information provided in her witness statement.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1b is proved.

The panel therefore found this charge proved.

Charge 1c.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

c. evidence of administration of medication to Service User J otherwise than in accordance with their prescription;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel considered that the evidence before it suggests that you accept that issues surrounding the management and administration of controlled drugs existed at the Home. The panel noted Mr Olphert's written submissions as to facts, which set out: *'it is clear that Mr Hunt admits there were issues with controlled drug management.'.*

The panel had regard to the incident investigation report, dated 7 November 2016, in which you outlined that you had found a total of 15 errors relating to the Controlled Drug Log for Service User J. The panel also had sight of the Controlled Drug Log for Service User J, and the associated MAR Charts for Service User J, which set out Service User J's prescribed dose of their medication, and the time and frequency of the administration of such medication. However, the panel noted the discrepancies namely that the MAR Chart showed medication given to Service User J at 6pm and 12pm which left six hour gap instead of 12 hours as noted on Service User J's prescription.

The panel further noted an email, dated 22 October 2015, to nurses at the Home in which you set out the duties and expectations of the Home in relation to medicines management. However, it bore in mind that this document was not provided to the CQC at the time of its inspection in October and November 2016. You said that the processes and procedures in respect of controlled drug management were in place at the relevant time, and that, as Area Manager, it was not your role to ensure that the procedures were being followed by nursing staff at the Home, as you were not on site at all times to ensure compliance.

The panel noted that Witness 1's evidence in respect of charge 1c was based upon the information which she received from a pharmacist colleague at the CQC during the time of the inspection. The panel recognised that this evidence was hearsay, however the panel found Witness 1 could clearly recall the conversations which she had with her pharmacist colleague, and her colleague's findings in respect of this charge. Accordingly, the panel found Witness 1's oral evidence in respect of this matter to be clear, credible and consistent with the information provided in her witness statement.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1c is proved.

The panel therefore found this charge proved.

Charge 1d.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    d. unclear records pertaining to authorisation of a change of prescription for medication for Service User J;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel noted Witness 1's oral evidence in respect of this charge, which it found to be clear and consistent with her witness statement, which states:

'This dose was then changed to 'three to be taken twice daily' on 21 October 2016, however the records did not clearly state who had authorised this change of dose. We discussed this with the deputy manager who believed that the GP had authorised the change but could produce no evidence to confirm this was the case.

[…]

Where the dosage of medicines were changed, it was not clearly documented when the dose had changed or who had authorised the dose change. The Abbey Care Village medicines policy at Exhibit KT10/A stated that a GP may change the dose of a medication e.g. from taking two tablets to one. It stated at page 10 that wherever possible the GP should write the changes on the MAR sheet; and that where changed by means of a verbal order, the Home should carefully record who took the telephone call, the time of the call, the name of the person who called and the changes made; read back the information, spell out names of medication and ask the GP to repeat the message to another member of staff. Both staff then were to sign the MAR sheet to confirm the change. Written confirmation should be requested by fax, letter or by issue of a new prescription.'

The panel also had regard to the Abbey Care Village Medicines Policy (the Medicines Policy) and the MAR Charts and the Controlled Drug Log for Service User J. It noted the wording of the Medicines Policy confirmed Witness 1's evidence.

The panel had regard to your evidence in respect of this charge. You said that the GP who regularly visited the Home authorised a change of prescription for the medication for Service User J. The panel had taken into account your oral evidence in respect of this matter, in which you said:

‘I did quite an in-depth investigation at the time. I mean, which obviously took quite a lot of detail. I have got copies -- I looked at it and there was [sic] records there, and there is a prescription had actually been changed by the visiting GP. What it said was that the MAR charts stated that Zomorph was administered four times a day and the controlled drugs book states twice a day. This was pertaining to two nurses that had administered the medication at the time. When I contacted Dr 1, obviously, he came and had a look at it and altered the prescription.’

The panel noted, however, that there was no evidence before the panel today of an amended prescription signed by Dr 1 in respect of Service User J, nor had it received evidence to demonstrate that this change had been appropriately documented in line with the Medicines Policy, therefore it could not be satisfied that this change had been appropriately documented.

The panel also heard your evidence in respect of charge 1 as a whole, that you were not at the Home sufficiently frequently, given your role as area manager, to ensure that other nursing staff were compliant with the policies and procedures that were in place at the Home.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1d is proved.

The panel therefore found this charge proved.

Charge 1e.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    e. you did not arrange training for care assistants in respect of being the second signatory for medication administrations;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel noted Witness 1's oral evidence in respect of this charge, which it found to be clear and consistent with her witness statement. The panel accepted Witness 1's evidence that you would be the person responsible for arranging this training as the manager and nominated individual at the Home. The panel also had regard to the Medicines Policy, which states:

> *'Appropriately trained care assistants may be asked to countersign the dangerous drug administration record book'.*

You told the panel that training for care assistants in respect of being a second signatory for medicines administration was carried out by a third-party company. However, you said that this training had been 'pulled from underneath you' as the company had not been paid by the Directors of the Home. You said that you attempted to secure other training providers to attend the Home and carry out the relevant training, but companies would not deal with the Home due to its reputation for failing to pay invoices. You said that you had arranged for, Boots, an external provider to attend the Home and carry out training based around Boots' medicines systems with senior care assistants. You said that, following the CQC inspection, you contacted the Clinical Commissioning Group (CCG) to attend and conduct a training session on medicines for the staff at the Home.

The panel had regard to all the information before it, it noted the Medicines Policy but concluded that there was no evidence before it of compliance with this policy. It heard your explanation that the financial constraints created difficulty in securing the appropriate training for staff at the Home however concluded that, as the manager of the Home, it was your responsibility to ensure that staff were provided with the appropriate training, including such training in respect of being the second signatory for medication administrations.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1e is proved.

The panel therefore found this charge proved.

Charge 1f.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    f. unclear or no records pertaining to authorisation of a change of prescription for medication for Service User F;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel noted Witness 1's oral evidence in respect of this charge, which it found to be clear and consistent with her witness statement. which states:

'We looked at the MAR for Service User F who was prescribed Trazodone 50mg capsules on the MAR starting 30 September 2016 at a dosage of one capsule twice daily (produced as Exhibit KT/11). When we looked at the new MAR starting 28 October 2016 the dosage had been changed by hand on this MAR to two capsules twice daily. There was no record either on his MAR or in his care plan file or in the GP/ professional visits or in his daily notes, to say who had authorised this change in dosage or on which date. We asked the deputy manager about this issue and she could not provide any further detail.

[…]

Where the dosage of medicines were changed, it was not clearly documented when the dose had changed or who had authorised the dose change. The Abbey Care Village medicines policy at Exhibit KT10/A stated that a GP may change the dose of a medication e.g. from taking two tablets to one. It stated at page 10 that wherever possible the GP should write the changes on the MAR sheet; and that where changed by means of a verbal order, the Home should carefully record who took the telephone call, the time of the call, the name of the person who called and the changes made; read back the information, spell out names of medication and ask the GP to repeat the message to another member of staff. Both staff then were to sign the MAR sheet to confirm the change. Written confirmation should be requested by fax, letter or by issue of a new prescription.'

The panel also had regard to the Medicines Policy and the MAR Chart for Service User F. It noted the wording of the Medicines Policy confirmed the evidence of Witness 1.

You said the change of prescription would have been authorised by Service User F's GP, who would have instructed the nurse on duty to make a formal change on Service User

F's MAR chart. You identified the Medicines Policy as the relevant policy in place at the Home which set out the duties for the staff in relation to recordkeeping following a change in medication. You told the panel that staff were trained on this policy, which was also available to staff on shift.

The panel concluded that there was no evidence before it of an amended prescription signed by Service User F's GP, nor had it received evidence to demonstrate that this change had been appropriately documented in line with the Medicines Policy. The panel therefore could not be satisfied that this change had been appropriately documented, or had been documented at all.

The panel also heard your evidence in respect of charge 1 as a whole, that you were not at the Home sufficiently frequently, given your role as area manager, to ensure that other nursing staff were compliant with the policies and procedures that were in place at the Home.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1f is proved.

The panel therefore found this charge proved.

Charge 1g.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    g. all prescribed medication was not administered to Service User P on 28 October 2016

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

It had regard to Witness 1's oral evidence, which it found to be credible and consistent with her witness statement. The panel noted that Witness 1's evidence in respect of charge 1g contained information which she received from a pharmacist colleague at the CQC during the time of the inspection. The panel recognised that this evidence was hearsay, however the panel also had regard to Service User P's MAR charts, which supported the evidence of Witness 1. The panel noted that the last entry on Service User P's MAR chart is dated 27 October 2022.

You said that all patients had a MAR chart and processes to ensure that this documentation was being completed correctly, and that you were not at the Home sufficiently frequently, given your role as area manager, to ensure that other nursing staff were compliant with the policies and procedures that were in place at the Home.

On the basis of the information before it, and taking into account Service User P's MAR Chart, the panel could not be satisfied that any, or all, prescribed medication was administered to Service User P on 28 October 2016. The panel accepted your evidence that processes were in place to ensure that prescribed medication was administered and MAR charts were accurate, however it concluded that there was no evidence before it to demonstrate that you, or any other person at the Home, took sufficient steps to ensure compliance with these policies, such as an audit of medications, including after the CQC inspections took place in October and November 2016.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to

medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1g is proved.

The panel therefore found this charge proved.

Charge 1h.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    h. no record in the notes of the site of application of Service User S's transdermal patch;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

It had regard to Witness 1's oral evidence, which it found to be credible and consistent with her witness statement, which states:

> *'Service User S, was prescribed medicine to be administered through a transdermal patch. A copy of his MAR chart is at KT/13.This meant the medicine was applied to his skin and would be absorbed over time. There was a system in place for recording the site of application but this was not fully completed on the MAR and did not show where the patch had been applied. This is necessary because the application site needs to be rotated and the manufacturer recommends that the same site is not used for a period of 14 days to prevent side effects.'*

The panel recognised that this evidence was hearsay, however the panel also had regard to Service User S's MAR charts, which supported the evidence of Witness 1, whom it found to be a credible, professional witness. Additionally, the panel found Witness 1 could clearly recall the conversations which she had with her pharmacist colleague, and her colleague's findings in respect of this charge.

The panel also had sight of Service User S's MAR chart. It noted the copy of this MAR chart was largely illegible, however there was nothing recorded, which appeared to be consistent with what would be expected to be noted regarding the site of the application of Service User S's transdermal patch, such as a body map. The panel further noted that there was no other information before it which suggested that the site of application of Service User S's transdermal patch had been recorded in Service User S's notes.

The panel also heard your evidence in respect of charge 1 as a whole, that you were not at the Home sufficiently frequently, given your role as area manager, to ensure that other nursing staff were compliant with the policies and procedures which were in place at the Home. You said that MAR charts were available for all Service Users at the Home, and if these had not been completed appropriately, this was as a result of failings by individual staff members, which could not be attributed to you.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1g is proved.

The panel therefore found this charge proved.

Charge 1i.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    i. no MAR Chart available for Service User A;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's witness statement, which states:

> *'Service User A had moved to the Home on 1 November 2016 but despite being prescribed medication had no MARs in place. Staff could not confirm if his medication had been given but thought it had. We found that his medication remained unopened in the treatment room.'*

You asserted that every service user at the Home had a MAR chart. You said that when you arrived at the Home on the date of the first inspection, 25 October 2016, the CQC had conducted the inspection in a disorganised and chaotic manner, you said '*that office where they were sat, that was just a mass of paper. Everything was out of the folders. There was just - everything was just all over the floor.'.* You said the CQC may have failed to recognise the documentation which it had before it due to the chaotic nature in which the inspection was conducted.

The panel considered the function of the CQC and determined that the inspectors were at the Home in order to conduct a professional inspection subject to proper policies and procedures. The panel noted that the MAR chart for service user A was not before the panel, and seemingly was not located during, or at any point after the CQC inspections on 25 October 2016 and 2 November 2016. It concluded that a MAR chart would be a record

that should be easily available and would be universally recognised by any CQC inspector. The panel therefore rejected the suggestion that Witness 1 or her colleagues may have failed to recognise the MAR chart.

The panel accepted Witness 1's evidence, that the CQC had found unopened medication in relation to Service User A, and found this to be consistent with her evidence that there was no MAR chart available for Service User A. The panel found Witness 1's evidence in respect of this charge to be clear and credible

In light of this, the panel found Witness 1's evidence on this matter to be preferable and determined that, on the balance of probabilities, there was no MAR Chart available for Service User A.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1i is proved.

The panel therefore found this charge proved.

Charge 1j.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    j. medication was administered covertly to Service User B and/or Q and/or K without proper consideration of issues of consent and/or proper assessment and/or proper form of authorisation;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel accepted Witness 1's evidence, it found her oral evidence to be clear and consistent with her witness statement. It found that she was clear as to what the requirements for consideration of issues specified in charge 1j required, in that she said:

> *'We expect for covert medication that there is a capacity assessment, a best interest assessment decision, the details that the parties that were involved, that there is correspondence from the pharmacy about how to give medication covertly and would it -- and if there's any particular medicines that you can't give in, say, a yogurt or a food product. So we would expect details around exactly how they were to be administered.'*

Witness 1 said there was not a problem with the Medicines Policy, however it was not being followed.

You gave evidence about the process for administration of covert medication, including that it was authorised by Dr 1, or another GP, with full consideration of the method of administration, and that records would require a counter-signature.

The panel also heard your evidence in respect of charge 1 as a whole, that you were not at the Home sufficiently frequently, given your role as area manager, to ensure that other nursing staff were compliant with the policies and procedures which were in place at the Home. You said that MAR Charts and all relevant documents were available for all Service Users at the Home, and if these had not been completed appropriately, this was as a result of failings by individual staff members, which could not be attributed to you.

The panel had regard to the documentary evidence before it, it considered the Medicines Policy which sets out, in relation to cover administration of medicines:

> *'Before medicines can be administered covertly, there must be a full assessment of the resident by a multidisciplinary team which should include the GP or Consultant, in accordance with the Mental Capacity Act 2005. The team's decision to administer must be fully documented on a Restrictive Practice Assessment form in the resident's care profile, together with a review date.*
>
> *The team must also list the alternative formulations considered (crushing tablets is outside their product license and alternatives should be considered wherever possible). The team mist also list which medicines are to be administered covertly and how*.'

You said that when you arrived at the Home on the date of the first inspection, 25 October 2016, the CQC had conducted the inspection in a disorganised and chaotic manner, you said '*that office where they were sat, that was just a mass of paper. Everything was out of the folders. There was just - everything was just all over the floor.'.* You said the CQC may have failed to recognise the documentation which it had before it due to the chaotic nature in which the inspection was conducted.

The panel considered the function of the CQC and determined that the inspectors were at the Home in order to conduct a professional inspection subject to proper policies and procedures. The panel noted that the three forms of document required for the administration of covert medication in respect of the service users identified, as outlined in the Medicines Policy, were not before the panel, and seemingly have not been located during, or at any point after the CQC inspections on 25 October 2016 and 2 November 2016. It concluded that such record would universally be recognised by any CQC inspector. The panel therefore rejected the suggestion that Witness 1 or her colleagues may have failed to recognise the proper recording of covert medications. It concluded that,

on the balance of probabilities, medication was administered covertly to Service User B and/or Q and/or K without proper consideration of issues of consent and/or proper assessment and/or proper form of authorisation.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1j is proved.

The panel therefore found this charge proved.

Charge 1k.

1. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as demonstrated by one or more of the following:

    k. Body maps and / or administration records had not been completed for one or more service users prescribed creams / ointments / lotions;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel accepted Witness 1's oral evidence, which it found to be clear and consistent with her witness statement. Witness 1 detailed that the CQC had looked at the records for three service users who had creams or ointments prescribed by their GP, and the CQC did not find body maps and/or records of the administration of such medication in respect of these service users, despite being told by care staff at the Home that such medication

had been administered. The panel found this evidence to be clear, credible and compelling.

You said that these documents existed for all service users and were located in individual service users' rooms. You said that when you arrived at the Home on 25 October 2016, the CQC had conducted the inspection in a disorganised and chaotic manner, you said '*that office where they were sat, that was just a mass of paper. Everything was out of the folders. There was just - everything was just all over the floor.'.* You said the CQC may have failed to recognise the documentation which it had before it due to the chaotic nature in which the inspection was conducted.

The panel considered the function of the CQC and determined that the inspectors were at the Home in order to conduct a professional inspection subject to proper policies and procedures. The panel noted that the body maps and/or administration records in respect of the three service users identified by the CQC were not before the panel and seemingly have not been located during, or at any point after, the CQC inspections on 25 October 2016 and 2 November 2016. It concluded that such a record would universally be recognised by any CQC inspector. The panel therefore rejected the suggestion that Witness 1 or her colleagues may have failed to recognise any such body maps and/ or administration records

The panel also heard your evidence in respect of charge 1 as a whole, that you were not at the Home sufficiently frequently, given your role as area manager, to ensure that other nursing staff were compliant with the policies and procedures which were in place at the Home.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to medications management and/or medications administration as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 1k is proved.

The panel therefore found this charge proved.

Charge 2

2. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as demonstrated by:

The panel considered the stem of this charge in relation to the role which you held at the Home and whether this role created a duty for you to ensure that there were adequate processes/procedures in place and/or being following in areas specified in charge 2. In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1, the witness statements of Dr 1 and Person D, and your evidence.

The panel concluded, for the same reasons as detailed in respect of the stem of charge 1, above, on the balance of probabilities, that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in areas specified in charge 2.

Charge 2a.

2. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as demonstrated by:

    a. on 02 November 2016, you were unaware of Service User A residing at the Home

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel considered Witness 1's evidence on this charge. It noted her witness statement, which states:

> *'Service User A had moved to the Home on 1 November 2016 […] In fact Damian Hunt was unaware that this service user was in fact residing at the Home. When the inspectors arrived at the Home on the second day of the inspection, 2 November 2016, Damian Hunt told us who had been admitted to the Home since the last visit on 25 October 2016, and did not refer to this service user. It was only following the review of the medication that we found that service user had been admitted to the Home.'*

The panel found Witness 1's evidence in respect of this charge to be vague, in that there was no evidence before the panel of the context of any specific conversation between you and Witness 1 which led Witness 1 to believe that you were not aware of Service User A residing at the Home on 2 November 2016.

The panel took into account your evidence, you said that you knew that this Service User was at the Home as he had been transferred to the Home from another facility following an arrangement which had been in place prior to the second CQC inspection on 2 November 2016. The panel found your evidence in respect of this charge to be clear and credible, in that you recalled of the date that the service users were admitted into the Home in the context of the circumstances when the CQC had placed an embargo on the admission of further service users to the Home.

The panel had sight of a record containing the details of the service users admitted to the Home between 27 October 2016 and 31 October 2016, which was provided by you for the purpose of these proceedings. It noted that Service User A's name on this record differs from that provided on the NMC schedule of anonymity. In the course of your oral

evidence, you confirmed that the details on the record you provided to be the correct name for Service User A, which the panel considered to be credible.

The panel concluded that the NMC had not provided any evidence which positively identified Service User A's name to be the one provided in the schedule of anonymity, over the name confirmed by you. In these circumstances, the panel was satisfied that confusion may have arisen during the conversation between you and Witness 1 due to this discrepancy surrounding Service User A's name, which may have led Witness 1 to consider that you did not know Service User A was residing at the Home at the relevant time. In all the circumstances, the panel could not be satisfied, on the balance of probabilities, that you were unaware of Service User A residing at the Home on 2 November 2016.

The panel therefore found this charge not proved.

Charge 2b.

2. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as demonstrated by:

    b. No prescribed medication was administered to Service User H, a new resident, between 22 October and 25 October 2016

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel bore in mind Witness 1's witness statement, which states:

'Service User H's MAR dated 22 October 2016, is the MAR chart for new resident Service User H which Inspector 1 took a copy of on 25 October 2016. It lists the service user's prescribed medication, which was due to begin on 22 October 2016, but is blank with no administration entries, giving the impression that no medication has been given to the resident between 22 October 2016 and the date we inspected, 25 October. Therefore we concluded that she was given no medication between those dates. The resident died on 31 October 2016 and we were told by nurse A that she was not on palliative care, however the medication which was prescribed for her was for pain relief. Failure to administer her medication for 4 days was therefore unacceptable. I would have expected Damian Hunt as manager to ensure medication was given and appropriately recorded.'

You told the panel that, at the relevant time, Service User H was on palliative care, and anticipatory medication was appropriately administered as required. You said that Service User H died a few days after the CQC inspection.

The panel noted that Witness 1's account contains hearsay evidence of both Inspector 1, and Nurse A. In respect of the hearsay evidence of Inspector 1, the panel noted that Witness 1 was clear about the conclusions reached on the basis of the MAR chart copied by Inspector 1, who is a professional CQC inspector. The panel therefore found Witness 1's evidence surrounding this issue credible. In consideration of the hearsay evidence of Nurse A, the panel considered that, although there was nothing before it to suggest that Witness 1 had not been told by nurse A that Service User H was not on palliative care, there was evidence before it surrounding concerns about Nurse A's competency. In light of this, the panel could not be satisfied that the information that Nurse A gave to Witness 1 was reliable.

The panel had regard to Service User H's MAR chart, and noted that all the medications noted on this chart, with the exception of levomepromazine, was indicated to be prescribed as 'when required'. It also noted that Service User H died around 4 days after

the first CQC inspection. The panel found this to be consistent with your evidence, which it found to be credible in respect of this charge. Accordingly, the panel concluded that, on the balance of probabilities, Service User H was on palliative care at the relevant time

The panel also concluded that, in light of the issues found proved surrounding the documentation administration of medications at the Home, Service User H's MAR chart could not be relied upon to conclusively demonstrate whether medications had or had not been administered to Service User H at the relevant time.

Accordingly, the panel could not be satisfied, on the balance of probabilities, that no prescribed medication was administered to Service User H between 22 October 2016 and 25 October 2016.

The panel therefore found this charge not proved.

Charge 2c.

2. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as demonstrated by:

    c. By 25 October 2016, for Service User Q, a new resident admitted on 21 October 2016, no care records or daily notes existed

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel considered the evidence of Witness 1, which it found to be credible and consistent with her witness statement, which sets out:

'We found that staff were failing to adequately assess and monitor service users' needs. We found that Service User Q, who had complex physical health care needs and was very frail, had been admitted to the home on 21 October 2016. When we commenced the inspection on 25 October 2016 her family spoke to Inspector 2 and myself. They informed us that when they had visited on 23 October 2016, no care records had been put in place for this service user. On 25 October 2016, we also found that there were still no care records or daily notes in existence for her. As I understand it this service user had just arrived from Sowerby House where there had been no records handed over, so it was essential that the Home produced these, as part of them saying they could meet her needs. The administration manager for the home, Person A, informed Inspector 2 and myself on 25 October 2016 that she had 5 days from admission… to complete this record. Inspector 2 told Person A that it was unacceptable to have no care records in place for the resident and that we would have expected to see the essential information about people's needs being in place on admission. We raised this matter with Damian Hunt, and later in the day a set of records were produced in respect if [sic] this service user which appeared very generic in nature and appeared to have the same content as other service users' records. I felt the record was inadequate as it did not cover the needs of the individual service user.'

The panel recognised that Witness 1's witness statement contained hearsay evidence of a conversation which Inspector 2 had with the family members of Service User Q, however, despite this, the panel found Witness 1's evidence in respect of this matter to be clear and credible. Witness 1 said that, in the circumstances, care plans should have been put in place immediately, which the panel accepted.

The panel had regard to your oral evidence, you said:

'I mean, to the best of my knowledge, there was care plans in place. Like I said, once people are admitted, we have a -- prior to them coming, they get a bundle of notes from the social services, like, which you formulate your care plans on, so it is like the needs and stuff like that. People should have been assessed prior to coming in, anyway, so there will be notes available to the staff and when staff -- when residents come in, the staff start writing the care plans. Like I said, everyone had -- the care plans were done on a memory stick, so each resident had -- it is a separate file, as it were, for the care plans. There will also have been daily notes there, so the staff will have wrote what the lady has done during the day, if their family has visited, if their GP has visited, so there will have been notes -- there will be notes there. I am not saying it was a full, complete care plan file, but there was notes there'

In response to the allegation that Service User Q's records were completed after it had been pointed out by the CQC inspectors that the records did not exist, and therefore were being typed up during the inspection, you said:

'I was unaware of that till that was pointed out but, I mean, like I said, the nurse, which was Nurse B, was in the office, anyway, so, I mean, she could have been updating care plans on the computer because she had access, which is her role, anyway.'

The panel bore in mind that there is a material dispute between you and Witness 1 as to whether relevant documentation, which has subsequently been produced, was available at the time of the CQC inspection on 25 October 2016.

The panel considered the function of the CQC and determined that the inspectors were at the Home in order to conduct a professional inspection subject to proper policies and procedures. The panel also found Witness 1's evidence to be clear and credible overall, even when taking into account the hearsay evidence contained within her witness

statement, in respect of this matter. The panel did not find your explanation, that Nurse B was updating Service User Q's care plan at the time of the inspection, to be credible.

The panel further noted that you were not able to answer with certainty that a care record was in place for Service User Q. In light of this, the panel found Witness 1's evidence on this matter to be preferable and determined that, on the balance of probabilities, no care records or daily notes existed for Service User Q by 25 October 2016.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 2c is proved.

The panel therefore found this charge proved.

Charge 2d.

2. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as demonstrated by:

    d. The care planning documents subsequently created for Service User Q were generic and not adequately updated.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel considered the evidence of Witness 1, which it found to be credible and consistent with her witness statement. The panel concluded that Witness 1 gave clear and reliable evidence as to why she found the care plan to be inadequate, and what would be normally expected for service users' care plans.

Witness 1 also gave evidence that staff at the Home were updating care plans at the time of the inspection on 25 October 2016. The panel considered Witness 1 to be credible as to this matter.

You did not directly address this charge, and you accepted that care plans may have been updated at the time of the CQC inspection.

The panel had regard to the documentary evidence, it considered that many of the entries on Service User Q's care plan were largely illegible, but it considered that those entries which were clear did not comply with the expectations as outlined by Witness 1.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 2d is proved.

The panel therefore found this charge proved.

Charge 2e.

2. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as demonstrated by:

    e. One or more care plans
        i. were not clinical in nature and/or

ii. Did not reflect specific care and/or nursing needs and/or
iii. Were generic / not completed accurately.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel considered the evidence of Witness 1, which it found to be credible and consistent with her witness statement, which states:

> *'Person A was the Home administrator and was working as a carer for a few weeks on the floor, when she had no formal health and social care qualification and no related qualifications in care. I spoke to her about her role and she informed me that she and Person D, the training manager, wrote the care plans, rather than nurses, which was concerning. We found that all the care records were compiled from a template the Home had, which Person A and… just changed minor elements in, such as the person's name. None of the care records appeared to be clinical. As manager I would have expected Damian Hunt as a registered nurse or via delegation to one of the other nurses, to have ensured that full, individualised care plans were produced for each of the residents, reflecting their specific care needs.*
>
> *[…]*
>
> *[Exhibits KT/16, KT/17 and KT/18] are the three care plans that I took copies of during the inspections, and are supposed to detail how to work with someone who has challenging behaviour. We found that there was insufficient information contained in these. All care plans were developed by Person D and Person A were not fit for purpose. These staff should not have been developing or writing these plans for people with complex nursing*

needs, as neither had the training or the qualifications of a nurse and were not qualified to do so.

[…]

On 2 November 2016 we reviewed [the]… Service Users' [A,C,D and E] files and found that Nurse B was in the process of completing Service User A's assessment. But other than name changes, all four of these service users' records contained exactly the same content of assessment and care plan information. Some of these documents had been assigned the wrong gender for people. We could not determine how these assessments, which were all direct images of each other, had been used to determine the actual needs of the individual service users'

You accepted that there were only two nurses at the Home, and at some points it was only Nurse B who could complete care plans, therefore *they 'could have been more in-depth'*. You also said that Person D wrote care plans under the direct supervision of Nurse B.

The panel had regard to the documentary evidence and concluded that the care plans provided were generic, and agreed with your view that more detail was required. The panel determined that, as an unqualified member of staff, it was inappropriate for Person D to complete care plans, even if supervised by a nurse, as she did not have the qualifications or understanding of the complex clinical needs of service users, and therefore such care plans could not be clinical in nature and/or reflect such needs.

In all the circumstances, and having already determined that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in relation to assessments and / or care planning as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 2e is proved.

The panel therefore found this charge proved.

Charge 3

3. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to weight management as demonstrated by:

The panel considered the stem of this charge in relation to the role which you held at the Home and whether this role created a duty for you to ensure that there were adequate processes/procedures in place and/or being following in areas specified in charge 3. In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1, the witness statements of Dr 1 and Person D, and your evidence.

The panel concluded, for the same reasons as detailed in respect of the stem of charge 1, above, on the balance of probabilities, that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in areas specified in charge 3.

Charge 3a.

3. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to weight management as demonstrated by:

    a. Weight records only being available for residents on the upstairs unit;

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel heard the evidence of Witness 1, who said that no weight records were provided for residents on the downstairs units in the course of the CQC inspections in October and November 2019. The panel had regard to the Service Users' weight charts which were referred to in Witness 1's witness statement.

The panel considered your evidence. You said that the weight charts contained records which related to residents on both the upstairs and downstairs units. The panel found your evidence to be credible, in this regard, and that you clearly identified on the chart which records related to service users on the upstairs units and which related to residents on the downstairs units.

The panel had regard to the documentary evidence before it, in particular the Service Users' weight charts, which were annexed to Witness 1's witness statements. The panel noted that these weight charts were available to the CQC at the time of inspection in October and November 2016.

Accordingly, the panel was satisfied that the weight charts before it contained records in respect of residents on the upstairs and downstairs units. The panel concluded that it was likely that Witness 1 had been mistaken in her assertion that the weight records for downstairs residents was not available.

The panel therefore found this charge not proved.

Charge 3b.

3. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to weight management as demonstrated by:

    b. weight records were not up to date and/or completed in a timely manner;

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel had regard to the evidence of Witness 1, who states in her witness statement:

> *'On 25 October 2016 we could not find any weight monitoring records for the service users residing on the downstairs unit. We asked repeatedly for these records but none were produced. On 2 November 2016 I observed training manager Person D printing out the September 2016 weight chart for these downstairs service users. She stated that she had just completed filling in the information for that month. We saw that no weight records for any previous months had been completed on this sheet, despite it being set up for recordings across 12 months.*
>
> *We found that the registrant had not ensured action was taken to reduce the risk of malnutrition. We could not establish how the nurses and manager determined when service users lost weight, as staff were not recording this information in a consistent or timely manner. This lack of monitoring potentially meant action was not being taken and this posed significant the risks to service users' life, health and wellbeing.'*

The panel took into account that Witness 1 did not provide any further evidence or context for this assertion, and did not elaborate on the matters contained in her witness statement in respect of this charge.

The panel considered your oral evidence, in which you said that evidence of compliance with weight management procedures was provided to the CQC in the form of weight and feeding charts, MUST tools and referrals to specialist teams which demonstrates that

weight was properly monitored at the Home. You outlined for the panel the process which staff took to weigh service users, and that service users' weight records were recorded on their care plans by Person D, although the panel did not have sight of these care plans.

The panel had regard to the documentary evidence before it, in particular the Service Users' weight charts, which were annexed to Witness 1's witness statement. The panel noted that these weight charts were available to the CQC at the time of inspection in October and November 2016. The panel observed that there was evidence before it that a number of weight records had been completed, and there were comments recorded on individual records, including when service users had been seen by a GP and/or referred to a dietitian.

The panel concluded that there was insufficient information before it to prove that the weight records were not completed in a timely manner, as the panel is not able to determine when the records provided had been completed. Further, the panel reminded itself that it found that Witness 1's evidence in respect of charge 1a was not accurate, in that it considered that she may have been mistaken as to what the weight charts showed. Similarly, the panel could not be satisfied that Witness 1 had understood the Home's processes and procedures for weight management.

Accordingly, having found that some weight records were completed, including records which relate to October 2016, the panel concluded that there was insufficient evidence before it to be satisfied that the weight records were not up to date and/or completed in a timely manner.

The panel therefore found this charge not proved.

Charge 3c.

3. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to weight management as demonstrated by:

    c. no evidence of action taken when records available demonstrated that residents have lost weight;

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's witness statement which states:

> *'I found that staff consistently failed to adequately monitor service users' body weight. I would have expected that they would have been weighed monthly, those losing weight to be weighed weekly and BMI to be checked and the Malnutrition Universal Scoring Tool to have been adhered to. Only those service users who were resident upstairs had this undertaken. Entries in the service users' records which are kept in the upstairs area showed that [redacted], [redacted] and [redacted] had lost weight but the care records did not detail what action had been taken to mitigate the continued risk of weight loss. There was no evidence to show that a referral to the GP or dietician had been made and the nurses and senior staff we spoke with had not contacted these professionals'*

The panel considered your oral evidence, in which you said that evidence of compliance with weight management procedures was provided to the CQC in the form of weight and feeding charts, MUST tools and referrals to specialist teams which demonstrates that weight was properly monitored at the Home. You outlined for the panel the process which staff took to weigh service users, and that service users' weight records were recorded on their care plans by Person D, although the panel did not have sight of these care plans.

The panel had regard to the documentary evidence before it, in particular the Service Users' weight charts, which were annexed to Witness 1's witness statement. The panel noted that these weight charts were available to the CQC at the time of inspection in October and November 2016. The panel observed that there was evidence before it that a number of weight records had been completed, and there were comments recorded on individual records, including when service users had been seen by a GP and/or referred to a dietitian. The panel considered that these records were not as detailed as would be expected, however concluded that they demonstrated evidence of action taken by staff at the Home to record service users' weight.

The panel therefore found this charge not proved.

Charge 3d.

3. Did not ensure that there were adequate processes/procedures in place and/or being followed in relation to weight management as demonstrated by:

    d. The completion of Service User P's MUST tool was incorrect

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's witness statement which states:

> *Service User P had appeared to lose 9 kilogrammes in weight over 5 months. Inspector 2 found that incorrect completion of the MUST had led to no action being taken to contact the GP or dietician to raise with them that*

Service User P had lost weight. I do not currently hold a copy of the MUST or dietary care plan for Service User P… (referred to the CQC letter of 11 November 2016 at Exhibit KT/30).

The panel had regard to the CQC letter, dated 11 November 2016, which sets out:

'The inspectors looked at service users care records and found staff had completed a Malnutrition Universal Screening Tool (MUST), a nutritional assessment tool. They saw that staff had calculated the MUST incorrectly. On service user P's MUST it was recorded that on 28 May 2016 she weighed 56.9 kg; on 30 June 2016 they weighed 56.7 kg; on 31 July 2016 they weighed 49.75 kg; on 28 August 2016 they weighed 45.75 kg; on 10 September 2016 they weighed 47.9 kg and although an entry was dated 19 October 2016 no weight was recorded. The inspectors found that although service user P had lost 9 kg over the five-month period the deputy manager had recorded that zero for risk and did not note that the person had lost weight or was at risk of malnutrition. The inspectors found the incorrect completion of the MUST had led to no action being taken to contact the GP or dietician to raise with them that service user P had lost weight.'

The panel noted, however, that it did not have sight of the MUST in respect of Service User P which these findings were based on, therefore the panel could not independently verify this information.

The panel considered your oral evidence, in which you said that evidence of compliance with weight management procedures was provided to the CQC in the form of weight and feeding charts, MUST tools and referrals to specialist teams which demonstrates that weight was properly monitored at the Home. You provided in depth oral evidence about how MUST score was determined and actions taken to escalate concerns about Service User P, which the panel found to be credible.

In all the circumstances, and in the absence any independent evidence to substantiate the allegation specified at charge 3d, the panel could not be satisfied, on the balance of probabilities, that Service User P's MUST tool was incorrect.

The panel therefore found this charge not proved.

Charge 4

4. Did not ensure that the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

The panel considered the stem of this charge in relation to the role which you held at the Home and whether this role created a duty for you to ensure that there were adequate systems in place and/or being following in areas specified in charge 4. In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1, the witness statements of Dr 1 and Person D, and your evidence.

The panel concluded, for the same reasons as detailed in respect of the stem of charge 1, above, on the balance of probabilities, that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in areas specified in charge 4.

Charge 4a.

4. Did not ensure the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

    a. There was no evidence of references checked for Nurse A;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1, the witness statement of Person D and your evidence.

The panel had regard to Witness 1's oral evidence, which the panel found to be credible and consistent with her witness statement. She said that, at the time of the inspection, there was no evidence of references having been checked for Nurse A, and that you stated that as Nurse A had previously worked in the Home via an agency, the agency will have completed the relevant checks. The panel accepted Witness 1's evidence that you should have undertaken these checks when Nurse A began to work directly for the Home.

Person D, in her witness statement said:

'I think the agency mainly did the references checks but I am not sure.'

You said that your recollection on this matter was not clear, although you knew that Nurse A's references would have been initially checked by the agency, as you paid a premium for such a service. However, you said that you believed that, when Nurse A became an employee, she had provided the names of two referees, who had been checked and the evidence of which was placed on Nurse A's personnel file, which you produced in the course of this hearing.

The panel bore in mind that there is a material dispute between you and Witness 1 as to whether relevant documentation, which has subsequently been produced, was available at the time of the CQC inspections in October and November 2016. The panel noted the NMC's submissions on this matter that, although it is not suggested that you fabricated all of the documentation provided after the dates of the inspections, it is a matter of luck and not your judgement, that some of the material was subsequently located by you, and certainly not as a result of a well-managed, organised and adequate system of record keeping being in place at the Home.

You said that all of the documentation which is now before the panel was available to the CQC at the time of the inspections, and it is as a result of the individual inspectors' disorganisation in carrying out their investigation that they were unable to locate the documentation at the relevant time. The panel considered the function of the CQC and determined that the inspectors were at the Home in order to conduct a professional inspection subject to proper policies and procedures. The panel also found Witness 1's evidence to be clear and credible overall. In light of this, the panel found Witness 1's evidence on this matter to be preferable and determined that, on the balance of probabilities, Nurse A's personnel file was not available at the Home at the time of the inspections on 25 October 2016 and 2 November 2016.

Despite this new evidence, the panel considered that there was no information before it to demonstrate that you had checked references for Nurse A when she became a full-time employee at the Home. The panel would have expected Nurse A's personnel file to have contained the references or at least a note confirming they had been obtained, had you done so.

In all the circumstances, and having already determined that you had a duty to ensure that there were systems in place and/or being followed for recruiting staff as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 4a is proved.

The panel therefore found this charge proved.

Charge 4b.

4. Did not ensure the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

b. There was no evidence of Disclosure and Barring checks for Nurse A;

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence, which the panel found to be credible and consistent with her witness statement. She said that, at the time of the inspections, there was no evidence of Disclosure and Barring checks for Nurse A. The panel accepted Witness 1's evidence that it was your responsibility to carry out these checks when Nurse A began to work directly for the Home.

You said the personnel file of Nurse A, which you provided in the course of this hearing, was available to the CQC at the time of its inspection and contained details of Nurse A's DBS certificate. You said that Nurse A had a 'portable' DBS certificate, which allowed any employer to check the validity of her DBS status with a code, but the Home also undertook a separate DBS check through a third-party company.

The panel bore in mind that there is a material dispute between you and Witness 1 as to whether relevant documentation, which has subsequently been produced, was available at the time of the CQC inspections in October and November 2016, including the documents contained within Nurse A's personnel file. The panel noted the NMC's submissions on this matter that, although it is not suggested that you fabricated all of the documentation provided after the dates of the inspections, it is a matter of luck and not your judgement, that some of the material was subsequently located by you, and certainly not as a result of a well-managed, organised and adequate system of record keeping being in place at the Home.

You said that all of the documentation which is now before the panel was available to the CQC at the time of the inspections, and it is as a result of the individual inspectors'

disorganisation in carrying out their investigation that they were unable to locate the documentation at the relevant time. The panel considered the function of the CQC and determined that the inspectors were at the Home in order to conduct a professional inspection subject to proper policies and procedures. The panel also found Witness 1's evidence to be clear and credible overall. In light of this, the panel found Witness 1's evidence on this matter to be preferable and determined that, on the balance of probabilities, Nurse A's personnel file was not available at the Home at the time of the inspections on 25 October 2016 and 2 November 2016.

The panel had regard to the documentary evidence before it, and noted that there was evidence of an enhanced DBS certificate in respect of Nurse A, dated 8 January 2016 contained within her personnel file. The panel concluded that, although it may have been good practice for you to carry out a new DBS check when Nurse A became a full-time employee at the Home in August 2018, it was not unreasonable for you to rely on the certificate issued seven months earlier.

The panel bore in mind the wording of the charge, it accepted Witness 1's account that the DBS certificate before it was not available to the CQC, however, it concluded that the DBS certificate provided demonstrates evidence of Disclosure and Barring checks for Nurse A.

The panel therefore found this charge not proved.

Charge 4c.

4. Did not ensure the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

    c. there was no evidence of risk assessment around Person B's suitability to be involved in the administration of medication;

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's evidence, who set out that there was no evidence in the staff file to show the reason why he ceased to work as a registered nurse. She said that you were aware that Person B had been removed from the NMC register as a result of a failure to deliver tracheostomy care safely, and that you felt no need to consider any risk posed by Person B in respect of administering medication.

The panel heard your evidence. You provided documents certificates which you said demonstrated that Person B had demonstrated his ability to administer medications safely.

The panel accepted your evidence, that Person B worked at Elizabeth House in a non-nursing role, under the remit of a different manager, Mr 2. The panel found your evidence in respect of this matter to be clear and credible

The panel had regard to the documentary evidence, including the staff rotas and sign in sheets for both the Home and Elizabeth House, which showed that Person B solely worked at Elizabeth House. The panel concluded that, as there was a manager in situ at Elizabeth House, the duties outlined in the stem of charge 4 can not be attributed to you, in respect of this facility and the staff who worked there. Accordingly, the panel were not satisfied that there was a duty placed on you to carry out, or provide evidence of, a risk assessment around Person B's suitability to be involved in the administration of medication.

The panel therefore found this charge not proved.

Charge 4d.

4. Did not ensure the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

    d. checks on the validity of information provided by recruitment agencies were not carried out;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1, the witness statement of Person D and your evidence.

The panel had regard to Witness 1's oral evidence, which the panel found to be credible and consistent with her witness statement, in which she stated:

> *'I would have expected Damian Hunt as the manager to personally check the accuracy of the information within these documents. Damian Hunt confirmed that he had not checked the validity of the information from Freelance Care Recruitment Agency Limited or the information that Equinox had supplied. We made Damian Hunt aware of the risks posed from not having such information and that in the absence of a CQC-registered manager he was directly accountable for these staff whilst working at the Home'*

The panel heard your evidence that the Home paid a premium fee to the agencies which it used for staffing and therefore you trusted that the information which the agencies provided was correct. You said that you trusted the agencies to discharge their role properly to ensure that staff were appropriately qualified to work at the Home, however you accepted that further checks ought to have been conducted.

Person D, in her witness statement said:

> *'I think the agency mainly did the references checks but I am not sure.'*

The panel bore in mind your partial admission to this charge, and concluded that it would be expected of a manager of a care home to carry out checks on the validity of information provided by third-party recruitment agencies.

In all the circumstances, and having already determined that you had a duty to ensure that there were systems in place and/or being followed for recruiting staff as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 4a is proved.

The panel therefore found this charge proved.

Charge 4e.

4. Did not ensure the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

    e. checks on the validity of information provided by nurses about their NMC registration were not carried out;

This charge is found proved

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1, the witness statement of Person D and your evidence.

The panel had regard to Witness 1's oral evidence, which the panel found to be credible and consistent with her witness statement, as detailed in charge 4d. She said that if evidence of such checks had been made available to the CQC, the Home would not have been in breach of CQC regulations in this respect.

Your evidence was that the agency provider provided a pro-forma document containing the relevant information and that, following this, the NMC PIN was to be checked to ensure that the individual was registered and had no restrictions, as you accepted that you could not rely on the agency pro-formas. You said that this check was completed by the relevant administrator. The panel noted that there was no evidence that these checks had been carried out, although you suggested that these checks would be printed off and kept in a folder in the office, no such print outs or folder were produced for the panel.

The panel took into account the witness statement of Person D, which sets out:

> *'We used quite a lot of agency staff, mainly nurses or night staff. At first I couldn't understand it but we could never get permanent nurses to stay. I think the agency mainly did the references checks but I am not sure. Mr Patel would often arrange for agency staff to come in. They would turn up without us knowing or expecting them, and when we questioned where they had come from they said "Director A sent us".'*

Having regard to Person D's evidence, alongside the sign in sheets for the Home, the panel considered it would not be feasible that the details of agency nurses, including their NMC PINs had been provided to the Home before they arrived on the day of their shift. The panel concluded, in the absence of evidence of such checks being carried out, that it was more likely than not that checks on the validity of information provided by nurses about their NMC registration were not carried out.

In all the circumstances, and having already determined that you had a duty to ensure that there were systems in place and/or being followed for recruiting staff as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 4e is proved.

The panel therefore found this charge proved.

Charge 4f.

4. Did not ensure the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

    f. you did not carry out an adequate assessment of the suitability of Person C's position at the Home given his fitness to practise history;

This charge is found proved

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence, which the panel found to be credible and consistent with her witness statement. She said that it was clear from the NMC website that there were concerns relating to Person C's honesty, in relation to his failure to disclose a conviction in 2014 for irregularities in accounting records.

You said that Person C had made you aware of his fitness to practise history in September 2016, and accepted that you had not considered the implication of him working at the Home, nor had you taken any further action in respect of this disclosure.

The panel concluded that you should have, and did not, carry out a proper assessment on the suitability of Person C's position at the Home when you became aware of his fitness to practise history.

In all the circumstances, and having already determined that you had a duty to ensure that there were systems in place and/or being followed for recruiting staff as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 4f is proved.

The panel therefore found this charge proved.

Charge 4g.

4. Did not ensure the systems in place and/or being followed for recruiting staff were appropriate as demonstrated by:

    g. you did not carry out an adequate assessment of the suitability of Person A for her position in light of her criminal conviction;

This charge is found proved

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence, which the panel found to be credible and consistent with her witness statement, which sets out:

> *'Person A had been employed by the Home in June 2016. She was a care assistant who had been promoted by Damian Hunt to Home Administrator. I reviewed her personnel file and found a very basic application and noticed a conviction for drink driving in November 2014. (A copy of her application and DBS enhanced disclosure check is produced as Exhibit KT/29). When I spoke with Damian Hunt on 25 October 2016 about what checks he had carried out in respect of this employee, Damian said that she had told him about the conviction and he had taken this at face value. There was nothing to indicate that anything had been done independently to verify this information or that any risk assessment had been carried out.'*

The panel considered your oral evidence, in which you said:

> *'She did disclose that, and she wasn't driving to work, she was getting a lift off her husband at that time. She didn't come in, like, intoxicated or smelling of drink. She was an administrator in the office, working eight till one at that time because she had a family. She disclosed everything to me. It was on a DBS. What she said to me is that she had an argument with her husband and she was driving -- went home after -- had a drink and drove home to her mother's house and, obviously, got stopped for drink-driving. Under her name, she fully disclosed it and obviously under the -- what is the word I am looking for? I can't think what the word is, but obviously, like I said, she had been transparent about it and I didn't feel that there was a risk there to patients, other staff members or Person A herself. I felt, like I said, that she had disclosed it, she give a rational excuse for it, what happened, and I didn't feel that it warranted anything else. Like I said, it was noted in her file that she had had that. Yes, in hindsight, I probably should have done a risk assessment on her but, like I said, I didn't feel as though that she was a risk.' [sic]*

The panel considered your evidence and noted that you had done some form of assessment in that you had considered the risks and decided no further action was required. However, you had not recorded it, therefore neither you nor Person A's colleagues or supervisors would have known how you made a judgement, including any risks consequential upon Person A's conviction.

The panel next took into account Person A's job role. It accepted that, had she been employed at the outset as an administrator, she is unlikely to have required a more comprehensive risk assessment, as she was unlikely to have clinical responsibilities. However, the panel noted that Person A had originally been recruited as a care assistant, when she would have had such duties. Accordingly, the panel concluded that a fully

reasoned risk assessment should have been, and was not, carried out at this point, which you seemingly accepted in the course of your oral evidence.

In all the circumstances, and having already determined that you had a duty to ensure that there were systems in place and/or being followed for recruiting staff as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 4g is proved.

The panel therefore found this charge proved.

Charge 5

5. Did not ensure that the systems in place and/or being followed for managing staff were appropriate as demonstrated by:

The panel considered the stem of this charge in relation to the role which you held at the Home and whether this role created a duty for you to ensure that there were adequate systems in place and/or being following in areas specified in charge 5. In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1, the witness statements of Dr 1 and Person D, and your evidence.

The panel concluded, for the same reasons as detailed in respect of the stem of charge 1, above, on the balance of probabilities, that you had a duty to ensure that there were adequate processes/procedures in place and/or being followed in areas specified in charge 5.

Charge 5a.

5. Did not ensure the systems in place and/or being followed for managing staff were appropriate as demonstrated by:

a. Permitting/ allowing non-nurse staff to write care plans

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1, and your evidence.

The panel had regard to Witness 1's oral evidence, which the panel found to be credible and consistent with her witness statement, which sets out:

> *'Person A was the Home administrator and was working as a carer for a few weeks on the floor, when she had no formal health and social care qualification and no related qualifications in care. I spoke to her about her role and she informed me that she and Person D, the training manager, wrote the care plans, rather than nurses, which was concerning..*
>
> *[…]*
>
> *Service User A had told us during the visit that she was an administrator, training manager, registered manager and personal assistant to Damian Hunt but could not detail what qualified her to write the care plans and assessments for service users.'*

The panel noted that the reference to 'Service User A' in Witness 1's statement was likely an error, which should read 'Person D'.

You said that Person D sometimes took a role in typing the updating of care plans which had been considered by nursing staff – probably Nurse B given her full-time position. You stated that this would only be done with proper oversight by the nursing staff, and that this was reasonable to ensure that care plans were completed in a timely manner given the staffing issues present at the Home.

You said that you had no knowledge of Person A taking a role in care plans, and that in your view this would not have been appropriate.

The panel took account of all the evidence before it, and bore in mind its finding in respect of charge 2e, above. The panel determined that, as unqualified members of staff, it was inappropriate for Person D or Person A to complete care plans, even if supervised by a nurse, as they did not have the qualifications or understanding of the complex clinical needs of service users, and therefore such care plans could not be clinical in nature and/or reflect such needs.

The panel accepted your evidence that you were unaware that Person A was writing care plans, however in all the circumstances, and having already determined that you had a duty to ensure that there were systems in place and/or being followed for managing staff as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 5a is proved.

The panel therefore found this charge proved.

Charge 5b.

5. Did not ensure the systems in place and/or being followed for managing staff were appropriate as demonstrated by:

    b. staff members were not consistently signing in for shifts

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence, which it found to be credible and consistent with her witness statement, and staff sign in records annexed to her witness statement. She said that the CQC found that agency staff were not consistently signing in and it could not be established when agency nurses or carer workers were on site from the staff sign in records.

Your evidence was that staff were signing in 'religiously', as without accurate sign in records they would not be paid by Director A. You acknowledged that the CQC required a signing in sheet to ensure that staff movements on-site, including to the bins or between units, was required. Your evidence was that this was brought in, and when on-site you encouraged compliance yourself, but that the staff were only willing to sign in on the existing book to ensure payment.

The panel had regard to the documentary evidence including sign in records and staff rotas, however it could not be established from these records who had signed in, and if all staff on the premises had correctly signed in, as agency staff were not named on rotas. The panel therefore could not be satisfied that staff were consistently signing in for shifts.

The panel heard your evidence, that you made attempts to ensure compliance with the CQC's recommendations in respect of staff sign in records, and on your own account your attempts failed. The panel determined that, as the manager of the Home you were responsible for ensuring that staff complied with such policy.

The panel therefore found this charge proved.

Charge 5c.

5. Did not ensure the systems in place and/or being followed for managing staff were appropriate as demonstrated by:

    c. staff sign-in times were not always accurate to the time that staff were on site;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence, which it found to be credible and consistent with her witness statement, and staff sign in records and rotas annexed to her witness statement. The panel heard that Witness 1 had seen Nurse A and other staff members working on site some three hours after they had recorded that they had left the building

Your evidence in respect of this charge was the same as that in respect of charge 5b, above, and that some of the staff lived in the facility, so may have been present after their shift had ended.

The panel had regard to the documentary evidence including sign in records and staff rotas, however it could not be established from these records who had signed in, and if all staff on the premises had correctly signed in, as agency staff were not named on rotas. The panel further noted that the sign in sheets reflected the times marked on the staff rota, which may not necessarily have reflected the actual hours worked. The panel found Witness 1's evidence to be credible and compelling, and therefore accepted that she had seen Nurse A working at the Home three hours after she had recorded that her shift had ended. The panel was therefore satisfied that, on the balance of probabilities, staff sign-in times were not always accurate to the time that staff were on site.

The panel heard your evidence, that you made attempts to ensure compliance with the CQC's recommendations in respect of staff sign in records, and on your own account your attempts failed. The panel determined that, as the manager of the Home you were responsible for ensuring that staff complied with such policy.

The panel therefore found this charge proved.

Charge 5d.

5. Did not ensure the systems in place and/or being followed for managing staff were appropriate as demonstrated by:

    d. you did not have sufficient oversight of staff who were working at the Home;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence, which it found to be credible and consistent with her witness statement, and staff sign in records and rotas annexed to her witness statement. She said that you were unable to provide sufficient information about the staff working at the Home.

The panel heard your evidence, that as area manager responsible for five care homes, you were not in the position to oversee the day-to-day staffing of the Home, nonetheless you had involvement in recruitment and agency staffing to the extent that you were able to ensure proper staffing levels at the Home.

The panel took account of all the evidence before it, and bore in mind its finding in respect of charges 5a-c, above. The panel determined, in light of its findings in these charges, you did not have sufficient oversight of staff who were working at the Home.

In all the circumstances, and having already determined that, as the manager of the Home, you had a duty to ensure that there were systems in place and/or being followed for managing staff as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 5d is proved.

The panel therefore found this charge proved.

Charge 5e.

5. Did not ensure the systems in place and/or being followed for managing staff were appropriate as demonstrated by:

    e. you did not ensure that staff were working safe hours

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the oral evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence, which it found to be credible and consistent with her witness statement, and staff sign in records and rotas annexed to her witness statement. She said that she, alongside other CQC inspectors had observed from documents including sign in sheets and MAR charts that staff had worked excessively long shifts, including shifts of 24, 26, 32, 44 and 72 hours on duty.

You said that no staff member at the Home worked 72-hour shifts, and this finding by Witness 1 was a result of the CQC's method of assessing shift patterns with reference to MAR charts. You said:

> *'staff, to my knowledge, did not work 72 hours, they didn't, I know they didn't.'*

You accepted in cross-examination that there were staff working longer than desirable shifts at times, but that given that staff lived on site, it may have appeared worse than it was in terms of their presence at the Home. Further, you said that given the staffing concerns, there were continued issues with ensuring staff were available. In light of this, you said that you did what you were able to do to ensure staff worked safe and appropriate hours in line with the working time directive.

The panel had regard to the documentary evidence before it, including the sign in sheets and MAR charts referred to in Witness 1's evidence. The panel preferred the evidence of Witness 1 in respect this charge. It did not regard your explanations as credible or compelling, and concluded that Witness 1's evidence was consistent with the difficulties in staffing which you reported. It concluded that, as the manager of the Home, you should have been aware if staff were working unsafe hours, and should have taken action to prevent this.

In all the circumstances, and having already determined that, as the manager of the Home, you had a duty to ensure that there were systems in place and/or being followed for managing staff as a result of your role at the Home, the panel determined that, on the balance of probabilities, charge 5e is proved.

The panel therefore found this charge proved.

Charge 7.

7. Did not promptly take action to ensure that staff sign in records were accurate at the Home after it was brought to your attention during the CQC investigation on 25 October 2016.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence in respect of this charge, which it found to be credible and consistent with her witness statement, which states:

> *'We found that the staff sign-in information was not correct in relation to the times that staff left the building, as Nurse A and a senior care worker… had recorded that they had left the building at 8am on 25 October 2016 following the completion of a night shift. However, during our inspection on that date we saw that they remained at the Home after 8.30am and that Nurse A was still working at the Home at 11am.*
>
> *We made Damian Hunt aware on the first day of our inspection that inaccurate recording of this type posed a significant risk in terms of ensuring sufficient staff were on duty and in taking action in the event of a fire or other emergency. We requested that he take steps to rectify this. On 2 November 2016 when we returned to the home for a second day, we found this inaccurate staff recording pattern persisted and that in fact none of the alleged agency staff on duty on that day had signed in.'*

The panel considered your written responses to the regulatory concerns, in which you stated:

'Signing in was done. Director A wanted an A4 book signed by staff after each shift with the times of them starting and finishing and this was faxed on a daily basis which he would scrutinise against payroll. […] There was separately a signing in book which combined both visitors and staff. CQC stated that staff should sign in every time they leave the building but sometimes they didn't do it.'

The panel found this account to be consistent with your oral evidence, in which you said:

'[…] with regards to the signing-in sheet, I've got - we bought another - we already had a visitors signing-in book, so we bought a separate - cos what CQC said about obviously the signing-in sheets to me was - cos she said, "How do staff sign in and out?" so I went through the book with them and she said, "Well, you need a signing-in book". I said - and I explained what I've just tried to explain to yourselves that - about how they get paid. She said, "Well, that's - that's not right. You need a signing-in book and, even if staff go out for a cigarette or go to the bins, they need to sign in and out of this staff signing-in book", and I said, "Well, that's not really practical. Staff - I mean, if they're nipping out ---" like I said, "The bins are over there", but that's what she wanted me to do, so I actually bought a book and staff wouldn't - and I put a memo up saying, "Staff - you need to sign in here", blah blah blah, but obviously they wouldn't do it. They would just sign in on this paper because that is, in effect, how they got paid' [sic].

The panel heard your evidence, that you made attempts to ensure compliance with the CQC's recommendations in respect of staff sign in records and on your own account your attempts failed. The panel determined that, as the manager of the Home, as detailed at charge 1, you were responsible for ensuring that staff complied with such policy. Further, the panel had no information before it to satisfy it that any steps that you did take to ensure staff sign in records were accurate following the first CQC inspection on 25 October 2016 were taken promptly.

The panel had regard to the documentary evidence provided by both you and exhibited by Witness 1. It noted the style adopted by staff when signing in at the Home, as it had sight of the signing in pages relating to 13 October 2016, and the period between the first and second CQC inspections, between 25 October 2016 and 2 November 2016. The panel observed the style of these signing in documents to be consistent, and could not identify any changes between the style of the first document, dated 13 October 2016, and the signing in sheets which were compiled after 25 October 2016. Accordingly, the panel determined that, although the sign in book may have changed, there was no material difference in the way staff signed in and out of the Home.

In all the circumstances the panel concluded that it could not be satisfied, on the balance of probabilities, that you promptly took action to ensure that staff sign in records were accurate at the Home, after it was brought to your attention during the CQC investigation on 25 October 2016.

The panel therefore found this charge proved.

Charge 8.

8. Allowed/permitted one or more residents to be admitted to the Home after being asked not to do so by the Care Quality Commission or agreeing that you would not do so.

This charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

It is accepted by both the NMC and you that an undertaking not to admit more residents to the Home was not signed and agreed until 1 November 2016. However, Witness 1 said

that issues surrounding the safety of the Home were raised in a feedback session following the CQC inspection on 25 October 2016, during which time you were put on notice that no new residents should be admitted to the Home. The panel had regard to the records of the feedback session and found such records to be silent on this point.

The panel had sight of a letter, dated 28 October 2016, from the CQC which offered you an opportunity to enter into a voluntary agreement (in the form of legal undertakings) whereby you would voluntarily agree to stop admissions to the Home. The panel also had sight of the voluntary undertaking, signed by you, dated 1 November 2016 at 15:30.

You said that residents were admitted to the Home on pre-arranged transfers from other facilities on 27 and 31 October 2016, which had been approved by social services, with the knowledge of the CQC inspection. The panel found your evidence to be credible in respect of this matter.

You said that it could not be assumed that you would know that there was an expectation not to admit new residents after you had received the letter dated 28 October 2016. The panel noted that this letter does not make reference to the requirement to immediately stop admissions to the Home.

Accordingly, the panel concluded that the embargo on admissions to the Home did not come into effect until the legal undertaking was signed by you at 15:30 on 1 November 2016. Accordingly, the panel determined that you had not agreed to cease admissions until this time, and the admissions on 27 and 31 October were not improper.

The panel therefore found this charge not proved.

Charge 9.

9. After 04 November 2016 did not provide an adequate and/or timely action plan for the Home, addressing all the concerns brought to your attention by the CQC/

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence, which it found to be consistent and credible with her witness statement. The panel considered that she outlined clearly the expectations of the CQC in relation to the action plan, and the communications which the CQC had with you surrounding the inadequacy of the action plans provided. She said that the action plan did not give due weight to the seriousness of concerns and set out how they would be resolved, who by and when. The CQC only requests action plans where there is a serious risk of harm.

The panel heard your evidence that the action plan you provided was drafted in collaboration with, and approved by, the local authority, and was therefore accurate. You said that you accepted that your action plan lacked timescales, however these were provided shortly thereafter. You said that this was a working document which was both a timely and adequate response to the CQC's requirements, especially in light of the time constraints on you to provide this document.

The panel had sight of the documentary evidence, including the action plans provided and the communication which the CQC sent to you in respect of these. The panel determined the action plan to be vague and lacking detail, especially in relation to the areas of concern identified by the CQC in the letter of intent, dated 4 November 2016. The panel considered the requirements of the CQC to be clear and manageable. It noted your defence surrounding the timescale you were given to provide this action plan. However, the panel concluded that, although this may have impacted the first action plan which you sent to the CQC, you were offered multiple opportunities to rectify the deficiencies identified in the action plan, and failed to do so to an adequate standard. In light of this, the panel found that, on the balance of probabilities, after 04 November 2016 you did not

provide an adequate and/or timely action plan for the Home, addressing all the concerns brought to your attention by the CQC.

The panel therefore finds this charge proved.

Charge 10a.

10. Permitted/Allowed Nurse A to work at the Home in breach of an interim conditions of practice order as follows;

    a. When there was not adequate supervision as directed by condition 1;

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1, the witness statement of Ms 4 and your evidence.

The panel had regard to Witness 1's oral evidence in respect of this charge, which it found to be credible and consistent with her witness statement. She outlined that one of the reasons for the inspection was a result of the concerns which Ms 3 raised, that Nurse A's conditions of practice order was not being met. She gave evidence that, when the CQC arrived at the Home on 25 October 2016, there was no other nurse on shift and was greeted by Nurse A. She said that it would appear that Nurse A had lied about the presence of Nurse B on shift, and that you had thought that, under any other circumstance, a Nurse sleeping whilst Nurse A was on duty would be sufficient to meet the conditions of practice order requirements.

The panel had regard to condition one, which reads:

> *'At any time that you are employed or otherwise providing nursing services, you must place yourself and remain under the supervision of a workplace*

line manager, mentor or supervisor nominated by your employer, such supervision to consist of working at all times on the same shift as, but not necessarily under the direct observation of another registered nurse who is physically present on or in the same ward, unit, floor or home that you are working in or on. It is not acceptable for your supervisor to be off-site and available by telephone.'

You gave evidence that you had taken action to comply with the conditions of practice order. You provided the panel with an annotated copy of the conditions of practice order, dated 10 November 2016, on which you had made notes on the measures required for compliance with the conditions of practice order. In respect of condition one, you had marked *'if nurse is sleeping on the unit is it ok' – Holly McGubben (NMC)'.*

The panel had regard to the documentary evidence before it. It considered the witness statement of Ms 4, a case officer at the NMC, which set out the search undertaken in respect of any communication which you may have had with the above-named case officer at the NMC, in November 2016. It sets out:

'I was asked to search all relevant cases related to nurse, Nurse A for reference to a conversation which took place between Damian Hunt and an employee at the NMC, possibly called Holly, on or around 10 November 2016.'

'Whilst carrying out the search I also reviewed the records for any which would have been created in the name of 'Holly'. I searched the following variations of the surname;

- *McGibben, Holly*
- *McGibbon, Holly*
- *McGibbons, Holly*
- *McGibbens, Holly*

I did not find any records created by a person called Holly, or any of the above variations during the search.

I did find a record of a conversation which took place in October 2016, which may be relevant. I exhibit this as LG/01.

I also checked the NMC registration system called WISER, which is separate from 'CMS' and 'TRIM' and confirm there is no recorded conversation on or around November 2016.

I can confirm therefore that from the search that I undertook I did not find any records made by the NMC of a conversation between the NMC and Mr Hunt in November 2016'

The panel bore in mind that Nurse A made admissions, that she breached condition one of the interim conditions of practice order, in the course of a substantive hearing which commenced on 6 March 2019.

The panel determined that a nurse who is asleep would not be available to supervise Nurse A in accordance with condition one. The panel did not find your evidence credible or plausible, that you were given assurance by the NMC that a nurse asleep whilst on duty was a suitable supervisor. The panel considered that, although there was evidence of a risk assessment undertaken by Ms 3 in respect of Nurse A's conditions of practice order, there was no evidence that you had taken steps to ensure that Nurse A complied with her interim conditions of practice order. Accordingly, the panel found that, on the balance of probabilities you permitted and/or allowed Nurse A to work at the Home in breach of an interim conditions of practice order where there was not adequate supervision for her as directed by condition one.

The panel therefore found this charge proved.

Charge 10b.

10. Permitted/Allowed Nurse A to work at the Home in breach of an interim conditions of practice order as follows;

    b. When she was not adequately assessed as competent to administer medications as directed by condition 2.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence in respect of this charge, which it found to be credible and consistent with her witness statement. She outlined that one of the reasons for the inspection was a result of the concerns which Ms 3 raised, that Nurse A's conditions of practice order was not being met. She gave evidence that, during the CQC's inspection on 2 November 2016, she asked for evidence that Nurse A had undertaken a successful medication competency assessment, as required by her interim conditions of practice order. She said that at no time was such assessment provided to the CQC.

The panel had regard to condition two, which reads:

> *'You must not administer medicines other than under the direct supervision of a registered nurse until you have been assessed as competent to do so. This means that another registered nurse must be present with you at all times whilst you are administering medicines until you have successfully completed a competency based assessment in the workplace, a copy of which should be sent to the NMC on completion.'*

You gave evidence that you had taken action to comply with the conditions of practice order. You provided the panel with an annotated copy of the conditions of practice order, dated 10 November 2016, on which you had made notes on the measures required for compliance with the conditions of practice order. In respect of condition one, you had marked *'stated she can administer meds on her own'– Holly McGubben (NMC)'.* The panel were not satisfied with the validity of this comment, due to the reasons contained in the statement of Ms 3, outlined in charge 10a, above.

You provided the panel with documentation which you said demonstrates that assessments were undertaken regarding Nurse A's medicines competencies on 19 July 2016 with Mr 2 and 24 October 2016 with yourself. You said that this documentation was available at the time of the CQC inspection, but the CQC inspectors did not find it due to their disorganisation.

The panel considered the function of the CQC and determined that the inspectors were at the Home in order to conduct a professional inspection subject to proper policies and procedures. It concluded that such records would be recognised by any CQC inspector. The panel therefore rejected the suggestion that Witness 1 or her colleagues may have failed to recognise the medication competency assessments conducted on 19 July 2016 and/or 24 October 2016.

The panel further noted that Mr 2, who undertook the first medications competency assessment on 19 July 2016 is not a registered nurse, and it therefore rejected the suggestion that this was a proper assessment as required by condition two. Indeed, the panel noted that Nurse A's conditions of practice had been continued at a NMC review hearing on 9 September 2016. This is inconsistent with her having successfully completed a competency based assessment on 19 July 2016.

The panel bore in mind that Nurse A made admissions, that she breached condition two of the interim conditions of practice order, in the course of a substantive hearing which commenced on 6 March 2019.

The panel determined that, on the face of the evidence before it, on the balance of probabilities, Nurse A was administering medications at the Home, in direct contravention of the interim conditions of practice order, before 24 October 2016. Accordingly, the panel found that, on the balance of probabilities you permitted and/or allowed Nurse A to work at the Home in breach of an interim conditions of practice order when she was not adequately assessed as competent to administer medications as directed by condition 2.

The panel therefore found this charge proved.

Charge 11.

11. Created a risk assessment document pertaining to Nurse A's employment at the Home, dated 31 September 2016, which was false because you had not formally considered the risks of Nurse A's employment at the Home as set out in the document.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel had regard to Witness 1's oral evidence in respect of this charge, which it found to be credible and consistent with her witness statement, which states:

> *'I asked Damian Hunt on 25 October 2016 what actions he had taken to ensure that was complying with her conditions of practice order and how he was managing the risk this presented. Initially, he wasn't aware of the previous risk assessment prepared by the previous manager (as above) and he didn't seem aware of the NMC interim order. Three hours after I spoke*

with him, he came back with a copy of a risk assessment which was dated 31st September 2016 and signed by him (Exhibit KT/26) and did not refer me to the risk assessment dated 7th October 2016 prepared by the previous manager, Ms 3. Clearly there is no such date as 31st September. Damian Hunt at that point confirmed to me that he was aware of the interim order.

[…]

The biggest concern I had in respect of Damian Hunt was that he appeared to be making things up. He said documents were available but was then unable to produce them. Some documents were then being produced, I believe in response to us raising issues. We witnessed staff retrospectively filling in people's daily records, overwriting people's existing care plans on the computer to suggest these were also available for other service users. Also Damian Hunt provided a risk assessment document for Nurse A three hours after asking, and with a non-existent date (31 September) (Exhibit KT/26). He tried to deflect his responsibilities and did not make himself accountable for the practices of the service. As the nominated individual he should have ensured the service was running properly. The service was in my opinion dangerous'

The panel heard your evidence in relation to this risk assessment. You said that you admitted that the document was created at the time of the CQC inspection, however you denied that this was false and said you had formally considered the risks of Nurse A's employment at the Home. You said that the document you provided to the CQC, dated 31 September 2016, was a copy of a risk assessment which you knew to exist. The panel had regard to your oral evidence, in which you said:

'when I went in to the room where […] the CQC were, it was just a mass of paperwork. Everything was on the -- there was -- they was sat round, like, in a horseshoe and all the paper was just spread across the floor. It was just a

mass of paper, but everything was there. Like I said, it was -- everything was there. I mean, she said to me about the nurses' file, and I said -- and she was saying about the risk assessments and stuff like that. I said: "Look," I said, "everything is there, I know everything is there." Everything was there. She said: "Well, there's nothing here, there's nothing -- I can't find," and I said: "Well, I have got the file -- the file isn't there," so I ended up going over -- because we had, like, memory sticks, the staff had memory sticks, so every resident had, like -- every resident's care plan was on a memory stick, so the staff then could go in and alter the care plan if their needs changed and stuff like that, the evaluations and updates were done, like handwritten on the -- because they used to print them after and then the evaluations were done handwritten, so I went over the road to Elizabeth House to Mr 2 and said: "Look, Nurse A's saying that they haven't got any risk assessments about the practice to order." He said: "Well, I've done an assessment on her, I've done an assessment." I said: "Well, I have," so I said: "Have you got anything on your memory stick to say that?" and he said no, so I said, look, so what we did, I said: "Look, we will type another one up now and I'll take it over and say this is, like, a copy that we have -- of one that we know has been done." So he typed it. I dictated to it to him, he typed it up and, truthfully, I didn't look at the thing, because I dictated it, I took it over to her, to Witness 1. I said: "Look, there's a copy of a risk assessment that I know is in that file," and that is the exact words I said to her: "That's a copy of one that I know is in that file."'

You said that this document was not false, as it was a copy of a risk assessment previously carried out, which fully considered the risks of Nurse A's employment at the Home.

The panel bore in mind that there is a material dispute between you and Witness 1 as to whether relevant documentation, which has subsequently been produced, was available at the time of the CQC inspections in October and November 2016. The panel noted the

NMC's submissions on this matter that, although it is not suggested that you fabricated all of the documentation provided after the dates of the inspections, it is a matter of luck and not your judgement, that some of the material was subsequently located by you, and certainly not as a result of a well-managed, organised and adequate system of record keeping being in place at the Home. You said that all of the documentation which is now before the panel was available to the CQC at the time of the inspections, and it is as a result of the individual inspectors disorganisation in carrying out their investigation that they were unable to locate the documentation at the relevant time. The panel considered the function of the CQC and determined that the inspectors were at the Home in order to conduct a professional inspection subject to proper policies and procedures. The panel also found Witness 1's evidence to be clear and credible overall. In light of this, the panel found Witness 1's evidence on this matter to be preferable and determined that, on the balance of probabilities, the documentation requested by the CQC was not available at the Home at the time of the inspections on 25 October 2016 and 2 November 2016.

The panel had regard to the documentary evidence before it. The panel first considered the risk assessment and management plan carried out by you on 16 September 2016, which identified the risk as 'drink driving/ conditions on practice'. It noted the potential risks identified were: '*risk to clients/ staff, Nurse A previously collapsed whilst on shift NMC advised to work with mentor to safeguard residents, also previous [illegible] in CRB'*. The actions to be taken on this risk assessment were identified as: *'must work alongside mentor (nurse) to ensure safety'*.

It next considered the risk assessment dated 31 September 2016. The panel accepted your evidence that this date was a typographical error. It noted that this document was titled 'risk assessment' and identified the relevant hazard as '*NMC restrictions*'. It noted the control measures noted to be already in place to be:

> *'A person who has undergone a competency course in administering medication and is registered by the NMC*

A staff member to stay on site whilst on duty

Have access to management via the phone at all times

An appointed person staying in the home will:

1. *Take charge when Nurse A is injured or falls ill, including calling an ambulance if required*
1. *Look after her and take over the shift and call the manager*
2.

Training on medication is carried out and records maintained

An individual assessment for medication to be carried out in line with NMC regulations

A duty of care to all persons in the home or on the grounds must be shown'

The panel noted that there was evidence before it of an assessment of competency regarding supply, storage and administration of medication carried out by Mr 2, dated 19 July 2016, but concluded that this was not a risk assessment, and could not be considered as such. The panel also had regard to evidence of a risk assessment purportedly carried out by you on 16 September 2016. The panel concluded that this assessment was a poorly considered assessment which did not sufficiently address the risks of Nurse A's practice. Were it a proper risk assessment there would have been no need for Ms 3 to consider the risks associated with Nurse A's employment on 7 October 2016. Nor would there have been a need for you to carry out a further risk assessment on 24 October 2016.

The panel compared the two documents of 19 July 2016 and 16 September 2016, and your explanation that the risk assessment provided, dated 31 September 2016, was a copy of a previously completed risk assessment. The panel found your account to be

unclear as to which risk assessment the document was replicating, and therefore did not find your evidence on this matter to be credible. The panel determined that the risk assessment dated 31 September 2016 purported to contain a more detailed consideration of these risks. However, there was no evidence before the panel to demonstrate that such risks had ever been previously considered by you. In light of this, and your acceptance that the document was created on the day of CQC inspection, the panel found that, on the balance of probabilities, this document was false because you had not formally considered the risks of Nurse A's employment at the Home as set out in the document.

The panel therefore finds this charge proved.

Charge 12.

12. Your conduct in Charge 11 above was dishonest because you thereby created a false record pertaining to your management of the employment of Nurse A at the Home.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, your evidence and the advice of the legal assessor.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of *Ivey v Genting Casinos UK Ltd t/a Crockfords* [2017] UKSC 67:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts…. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the*

defendant must appreciate that what he has done is, by those standards, dishonest.'

You gave evidence that you did not mean to create a false impression, in that you told the CQC that the risk assessment was a copy of a document already on Nurse A's file. You did not believe that your actions were dishonest.

The panel applied the standards of ordinary people. It concluded that, by creating the risk assessment and the contents contained within it, an ordinary, decent person would find your actions to be dishonest as you had created the document to inform the CQC of a risk assessment which you purported to have properly assessed, when you knew that you had not properly carried out such an assessment.

The panel also noted that at no time in your evidence did you assert that you had told Witness 1 that the document was a 'recreation'. You asserted that you told her it was a 'copy', thereby indicating it was a duplicate of the original. This would be regarded as dishonest by an ordinary, decent person.

The panel therefore finds this charge proved.

Charge 13.

13. On 25 October 2016 presented the risk assessment document, dated 31 September 2016, to the CQC inspector as evidence that you had considered the risks of Nurse A's employment at the Home as set out in the document, when you had not.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, the evidence of Witness 1 and your evidence.

The panel noted that it was agreed by parties that you presented the risk assessment document, dated 31 September 2016, on 25 October 2016. Having determined that this document was false because you had not formally considered the risks of Nurse A's employment at the Home as set out in the document as outlined in charge 11, above, the panel was satisfied that this charge is found proved for the same reasons as detailed at charge 11.

The panel therefore finds this charge proved.

Charge 14.

14. Your conduct in Charge 13 above was dishonest as you presented the document in order to create a more favourable impression of your management of Nurse A to the CQC.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence before it, your evidence and the advice of the legal assessor.

In reaching this decision, the panel had regard to the test for dishonesty set out in *Ivey v Genting Casinos.*

You gave evidence that you did not mean to create a more favourable impression to the CQC inspector as evidence that you had considered the risks of Nurse A's employment at the Home, in that you presented the risk assessment to the CQC as a copy of a document already on Nurse A's file. You did not believe that your actions were dishonest.

The panel applied the standards of ordinary people. It concluded that, by presenting the risk assessment and the contents contained within it to the CQC, an ordinary, decent

person would find your actions to be dishonest as you had produced the document to inform the CQC of a risk assessment which you purported to have properly assessed, when you knew that you had not properly carried out such assessment.

The panel also noted that at no time in your evidence did you assert that you had told Witness 1 that the document was a ‘recreation’. You asserted that you told her it was a ‘copy’, thereby indicating it was a duplicate of the original. This would be regarded as dishonest by an ordinary, decent person.

The panel therefore finds this charge proved.

For the avoidance of doubt, the panel recognises and accepts the evidence produced by you that, on 7 December 2016 the local authority closed the 10 safeguarding alerts raised by the CQC, following their inspection visits to the Home. However, the charges the panel have considered concern the period leading up to and including the dates of the visits, namely 25 October 2016 and 2 November 2016. It is also concerned with the period in the immediate aftermath of those visits. For the reasons stated, the panel have found proved a number of the charges faced by you. The fact that remedial steps that satisfied the local authority had been taken by 7 December 2016 cannot and does not alter those findings.

Fitness to practise

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

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Submissions on misconduct

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

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

Ms Quinton-Carter identified the relevant standards in support of the NMC's submissions that your actions amounted to misconduct. Ms Quinton-Carter submitted that the following parts of The Code have been breached, but of course the panel was able to consider any other parts as it saw fit.

> ***'Prioritise people – ensuring needs are recognised, assessed and responded to.***
>
> *1.2 – make sure you deliver the fundamentals of care effectively*
>
> *1.4 – make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

Practise effectively

8 – work cooperatively

8.2 – maintain effective communication with colleagues

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

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

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

8.6 – share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

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

10.3 – complete all records accurately and without any falsification

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

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

11.1 – only delegate tasks and duties that are within the other person's scope of competence – suggest this includes non-nursing staff

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

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

20 Uphold the reputation of your profession at all times

20.2 Act with honesty and integrity at all times

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

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'

Ms Quinton-Carter further submitted that your actions have proven fall far short of what would be expected of a registered nurse. Someone with significant managerial experience, lost control of a home for which they had overall responsibility. Leading to poor standards of care, poor records, and mismanagement of staff. Separately and together, this posed a significant risk of patient harm.

Ms Quinton-Carter submitted that the public would expect a nurse to act with honesty and integrity. They would expect nurses to uphold the reputation of their profession. This was a serious breach of a fundamental tenet of the nursing profession.

In light of this, Ms Quinton-Carter invited the panel to make a finding of misconduct.

You gave brief evidence at this stage.

You described to the panel your journey into becoming a registered nurse and what you were doing before qualifying.

You highlighted to the panel that you are currently under restriction by the hospital you work for. You explained you are not permitted to have any patient contact, which had significantly curtailed your work and in effect meant you had to shadow others. This had led to your decision to reduce your working week to two days and more recently to take an agreed unpaid leave. You stated that you are finding working like this difficult as you are not interacting with patients, and you feel broken. You said that since the incident occurred

it has affected your mental and physical wellbeing and that you just want to get back to nursing.

You said that you have no intention of returning to a managerial role and do not mind staying in a Band 5 role.

Mr Olphert submitted that in respect of the rules and standards which apply in the present case, the panel is invited to proceed with caution when extending the definitions within the Code to include nurses within a managerial role. Some of Ms Quinton-Carter's submissions, require an assumption that they extend to cover managers. Mr Olphert submitted that reading it in this way may, in respect of some of the Code, result in applying to you when they would not ordinarily.

Mr Olphert submitted that the panel could take into account the background context when considering misconduct. The fact that you had responsibilities in respect of a number of other homes, and that the owners of the homes had plainly expected you to take work far in excess of what you were able to achieve, are directly relevant to the question of whether your failures in respect of these allegations, amount to serious professional misconduct. These circumstances should not be regarded purely as mitigation.

Mr Olphert submitted that in respect of allegations 1, 2c, 2d, 2e, 4a, 4d, 4e, 4f, 4g, 5a, 5b, 5c, 5d, 5e, 7 and 9 the panel ought not conclude that the allegations amount to misconduct. Whilst they demonstrate a failure to ensure that processes and procedures were in place or being followed, the particular circumstances of the home, and the evident and woeful actions of the owners of the home provide valuable context. This context, it is submitted, ought properly to draw the panel to the conclusion that whilst there may have been a falling short in these circumstances, that falling short was not so serious that in all of the circumstances it would be regarded as deplorable by fellow practitioners.

Mr Olphert submitted that it is clear that you had significant issues trying to juggle and balance all of the commitments laid at your door by the owners who had left the various

homes and care services short of staff and in a dire position. He further highlighted that you were responsible for general oversight of the Home and what happened. He submitted that, notwithstanding the panel's findings, it remained a live issue whether the specific failures of the nurses on shift can be said to flow from your position as manager.

Mr Olphert submitted that in respect of allegations 10a, 10b, 11, 12, 13, 14, you pray in aid the same points raised above, but also recognised that by their nature those allegations are more serious. Mr Olphert submitted that your evidence was consistent in that you tried your level-best to manage and fire fight issues at both the home and other homes. The panel have found that you had overall responsibility, and plainly you will not resile from those findings, but even so, the panel should take account of the pressures upon you in terms of trying to discharge the personal responsibility you felt to all service users across all the homes in respect of which the owners expected you to have oversight.

Mr Olphert submitted that you invited the panel to consider each charge found proved in turn and consider whether in all of the circumstances and with reference to all that the panel know, have seen and have heard in the background which gave rise to the particular and challenging position which you found yourself, any or all of these matters amounted to serious misconduct.

Submissions on impairment

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

Ms Quinton-Carter submitted that your fitness to practise is unequivocally impaired. All four limbs of Grant are engaged not only by virtue of the finding of dishonesty (limbs 2, 3, 4) but in having overall responsibility for the running of the Home (limbs 1, 2).

Ms Quinton-Carter submitted that by your own admission, you had extensive management experience and that the panel had found that you had overall responsibility for the Home at the material time, up to and including the CQC inspection period. Whilst it cannot be said that any actual harm was caused to patients, the concerns are serious and wide-ranging and your conduct placed residents at unwarranted risk of harm.

Ms Quinton-Carter submitted that the panel may wish to consider whether this is conduct that can be remediated, and whether this has taken place in any way. Ms Quinton-Carter highlighted that the panel has heard that your online training is up to date, and whilst no evidence has been provided of this, it is unclear whether any of this training is directly relevant to the charges in this case. Ms Quinton-Carter further submitted, it does not appear that in the significant period of time that these proceedings (including the investigatory stage) have been ongoing, you have made any attempts to remedy the deficiencies pertaining to this case. This may inform the panel's approach to whether there is a risk of repetition.

Ms Quinton-Carter acknowledged that you were put in a difficult position, the Home was failing, there were financial issues, and you did not fully appreciate the depth of the problems. Ms Quinton-Carter emphasised that the panel has concluded that at the material time, you did have overall responsibility for ensuring adequate processes were in place and that these were followed. Ms Quinton-Carter submitted that the panel will no doubt bear in mind the passage of time that has elapsed and your practice since these allegations arose, as well as the fact that there are no prior regulatory findings in your name. It is also clear that your remorse for that period of your career, is significant.

Ms Quinton-Carter submitted that whilst you have demonstrated some, limited insight into the concerns, this is far from being sufficient at this stage. Although you clearly recognise

there were issues at the Home and have recognised some of your responsibility in this regard, insight and remediation at this stage is limited. Ms Quinton-Carter highlighted that by your own admission, you have not taken time to reflect on what went wrong and what could or should be done differently if ever you were to find yourself in such a position of responsibility again. Ms Quinton-Carter submitted it is insufficient to simply state that you will undertake no further managerial role.

Ms Quinton-Carter submitted that there is a clear public interest in the regulator taking action when nurses bear responsibility for failing care homes. Notwithstanding this conduct overall, honesty is a bed rock of the nursing profession, and to be dishonest in and of itself would and should lead to a clear finding of impairment in this case – in producing a false risk assessment for Nurse A, patients were placed at risk and the public would be disturbed to find the risk of her practising in the home and administering medications without supervision had not been properly assessed.

In light of this, Ms Quinton-Carter invited the panel to find impairment in this case on the grounds of public protection and public interest.

Mr Olphert submitted that the charges which have been found proved date back to 2016, some 5 years and 8 months ago. Mr Olphert highlighted that in that time you have not been subject to any further investigations nor have any clinical issues arisen. He stated that your primary employer during that time has been James Cook Hospital, where you have worked in primarily patient-facing roles in both theatres and in the Eye Day Unit. Mr Olphert submitted, that you have demonstrated that you are fit to practise as a nurse, and to practise well.

Mr Olphert submitted that there are some 11 references supplied from managers, line-managers, fellow nurses, ophthalmologists and doctors who have been willing to speak to your professionalism, compassion and dedication to your clinical work. Mr Olphert highlighted that the professional references deal directly with the overarching risks which

the panel are bound to have in mind when considering the issue of public protection and risk. Dr 2 notes that:

> *"Damian has always been forthcoming with information about potentially difficult patients in recovery. I have always found his judgement to be excellent and Damian has never shirked his clinical responsibility as an anaesthetic nurse."*

Mr Olphert submitted that the fact that there is specific comment about Mr Hunt's desire to be forthcoming and to take on responsibility and display good judgement are all factors which the panel will feel demonstrates mitigation against that risk.

Mr Olphert submitted that the general evidence about your patient care and compassion echoes the evidence of both Person D and Dr 1 who speak to the fact that whilst at the Home, Mr Hunt took the care of the service users seriously. Indeed, Dr 1 noted:

> *"Damian was always approachable and helpful. He clearly had the wellbeing of the residents at heart."*

Mr Olphert submitted that you have demonstrated real remorse into the issues which arose at the home and, it is submitted, has also demonstrated insight into how and when things went wrong and his role in them.

Mr Olphert submitted that you have acknowledged the failings, has recognised your role as a leader at the home and have apologised. Mr Olphert further submitted that it is plain from your evidence at the impairment stage, and the emotion you displayed, that you entirely understand the gravity of your conduct, and are very unlikely to repeat it.

Mr Olphert submitted whilst there is limited evidence of remediation, there is little by way of remediation which might be possible on the facts of the present case. Mr Olphert highlighted that it is clear from your evidence, that you made significant efforts to ensure your training and development have been maintained to the highest standard. You have

not sought to work in a management position since you left the Home. Adopting the adage ‘actions speak louder than words’ Mr Olphert submitted that had you wished to return to management in the 5 years since the allegation, you could have done so – there have been no active restrictions on your practice. Despite this, you have not. Mr Olphert submitted that you have remained in an area where you feel safe and proficient and where you can continue to offer a high standard of care.

In respect of the public component, Mr Olphert submitted that an objective observer in possession of all the material facts would not, in this case conclude that a finding of impairment was required.

Mr Olphert submitted that in this case, given the particular circumstances both in respect of your employment with the home – which were unique and challenging – and your subsequent employment and dedication to care for your patients and clinical work, a fully informed member of the public could and would conclude that you could practise free from restriction.

In light of this, Mr Olphert invited the panel to conclude that as a result of either a finding of no misconduct, or a finding of no impairment, or a combination of the two, that your fitness to practice is not impaired by reason of misconduct.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin) and *R (Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin).*

Decision and reasons on misconduct

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered that charge 1, in its entirety did amount to misconduct. By your failures to ensure there were adequate processes or procedures in place in relation to medication management and administration and/or they were being followed, that you were complicit in the poor management and running of the home, placing the service users at risk of harm. However, the panel acknowledges the circumstances, in that you were covering five homes and there were difficulties with the homeowners. However, the panel still find that notwithstanding these challenges your conduct would be considered as deplorable to fellow practitioners and amounts to misconduct. The panel had regard to the terms of the Code.
Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> ***To achieve this, you must:***
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*
>
> ***8 Work co-operatively***
> *To achieve this, you must:*
> *8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
> *8.4 work with colleagues to evaluate the quality of your work and that of the team*
> *8.5 work with colleagues to preserve the safety of those*

receiving care
8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
10.5 take all steps to make sure that records are kept securely

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

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:
18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs
18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person

is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

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

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

The panel determined that charge 2 in its entirety did amount to misconduct due to the wide ranging and serious breaches. By your failures to ensure there were adequate processes or procedures in place in relation to assessments and/or care planning and/or they were being followed, that you were complicit in the poor management and running of the home, placing the service users at risk of harm. The panel found that your conduct would be deplorable to fellow practitioners and amounts to misconduct. The panel had regard to the terms of the Code.
Specifically:

*'**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

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

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

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

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

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 considered that charge 4 did amount to misconduct as your actions fell short of what would be proper in the circumstance. The panel highlighted that it was crucial for you to have ensured there were adequate recruitment processes in place which were being followed, and thereby ensuring the Home hired the appropriate staff. The panel finds your conduct would be deplorable to fellow practitioners and amounts to misconduct despite the circumstances. The panel had regard to the terms of the Code.

Specifically:

‘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

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 determined that charge 5 in its entirety did amount to misconduct. By your failures to ensure there were appropriate systems in place and/or being followed for managing staff, you were complicit in the poor management and running of the Home, placing the service users at risk of harm. The panel found that your conduct would be deplorable to fellow practitioners and amounts to misconduct. The panel had regard to the terms of the Code.

Specifically:

‘8 Work co-operatively

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

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

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

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:
25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

The panel considered whether each of the charges 6,7 and 9 individually amounted to misconduct. However, the panel determined that in each case the charge did not amount to misconduct. In each case the panel considered whether the proved conduct related to your role as a registered nurse, to which the Code applied, or purely to your role as a manager. The panel determined that the failings purely related to your role as a manager. The panel did consider the second category of misconduct referred to in the case of *R (Remedy UK Ltd) v General Medical Council*. However, the panel was not satisfied that the conduct in these charges met the high threshold, required for conduct arising outside your role as a registered nurse, to be considered misconduct.

The panel determined that charge 10 in its entirety did amount to misconduct, as your conduct fell below what is expected of a registered nurse. By permitting/allowing a nurse to work at the Home in breach of their interim conditions of practice order, you placed the service users at risk of harm. The panel found that your conduct would be deplorable to

fellow practitioners and amounts to misconduct. The panel had regard to the terms of the Code.

Specifically:

*'**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

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

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

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

To achieve this, you must:

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

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

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

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 determined that charge 11 did amount to misconduct, as your conduct fell below what is expected of a registered nurse. By creating a false risk assessment document pertaining to a nurse at the Home, you put service users at risk of harm. The panel found that your conduct would be deplorable to fellow practitioners and amounts to misconduct. The panel had regard to the terms of the Code.

Specifically:

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

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

The panel determined that charge 12 did amount to misconduct, as your conduct fell below what is expected of a registered nurse. The panel found that your dishonest conduct would be deplorable to fellow practitioners and amounts to misconduct. The panel had regard to the terms of the Code.
Specifically:

*'**20 Uphold the reputation of your profession at all times***
To achieve this, you must:
20.1 keep to and uphold the standards and values set out in the Code
20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'

The panel determined that charge 13 did amount to misconduct, as your conduct fell below what is expected of a registered nurse. By presenting a false risk assessment document pertaining to a nurse at the Home to the CQC inspector, you put service users

at risk of harm. The panel found that your conduct would be deplorable to fellow practitioners and amounts to misconduct. The panel had regard to the terms of the Code. Specifically:

> ***'20 Uphold the reputation of your profession at all times***
> ***To achieve this, you must:***
> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'*

The panel determined that charge 14 did amount to misconduct, as your conduct fell below what is expected of a registered nurse. The panel found that your dishonest conduct would be deplorable to fellow practitioners and amounts to misconduct. The panel had regard to the terms of the Code.
Specifically:

> ***'20 Uphold the reputation of your profession at all times***
> ***To achieve this, you must:***
> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'*

In conclusion, the panel found that your 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, your fitness to practise is currently impaired.

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that service users were put at risk of serious harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel found that you demonstrated very limited insight into the impact of your conduct on service users in your care, your colleagues or the profession. The panel accepted you were working in difficult circumstances. However, the panel was of the view that you had not reflected as to your competence in managing the difficulties posed to you at the Home and your own limitations, capability and competence. The panel highlighted that despite being an experienced manager you had continued to work in a job for which you had not received a job description or contract of employment, and therefore did not appear to have a full understanding of what was required of you. When required to take on more responsibilities by your employer, you did so without any proper recognition that they were beyond your capabilities and without recognising the risks this posed to the service users at the Home. Indeed, the panel noted that despite describing the role as impossible to perform effectively you remained in post for a considerable period of time.

Whilst the panel noted your remorse which was clear throughout the proceedings, the panel also noted that your remorse appeared to relate primarily to the impact the situation has had on you, as opposed to the impact your conduct has had on service users. You stated that you were constantly 'firefighting', referring to the inability to hire staff and having to personally purchase basic items for the service users. Despite this you failed to

inform the authorities of these concerns which had the potential to cause risk of harm to service users.

The panel carefully considered the evidence before it in determining whether you have taken steps to remediate and strengthen your practice. The panel acknowledges that you stated you are up-to date with your training and that you are booked in for training session in October for ‘Immediate life support training’. However, the panel has not received any information to support this or information as to whether the training is relevant to the alleged conduct.

The panel is of the view that there is a risk of repetition should you be in a similar situation again. You have not, by your own admission, reflected on the role you have played in respect of the serious failings in the Home as identified by the CQC inspections, despite the significant passage of time. Nor have you reflected on your own limits and capabilities when faced with the challenges the Home presented. You have described feeling that it was a personal attack upon you by the CQC rather than consider your own contribution to the events. You have described the significant impact these proceedings have had on you but you do not appear to have considered how you would do things differently if faced with a similar challenging situation, nor as to how you would recognise the impact your decisions and actions may have on service users. The panel recognised that you have not had a managerial role since 2017 and have stated you have no intention of returning to such a role. However, the panel recognises that without a finding of impairment you might consider returning to a managerial role in the future.

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

The panel bore in mind the overarching objectives of the NMC: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case. Therefore, the panel also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

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

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

Submissions on sanction

Ms Quinton-Carter informed the panel that in the Notice of Hearing, dated 10 January 2022, the NMC had advised you that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired.

Ms Quinton-Carter submitted a striking off order is appropriate in light of the panel's finding of impairment on both public protection and public interest grounds. She highlighted to the panel that cases of dishonesty will always be deemed as serious. Ms Quinton-Carter submitted that your dishonesty centred on seeking to cover up that Nurse

A, who was subject to an interim conditions of practice order, had not been subject of a proper risk assessment. The risk assessment was fundamental in ensuring she was fit to practice, and your conduct gave the impression that it had been done when it had not. This posed a direct risk of harm to service users. Ms Quinton-Carter also submitted that the panel might consider that you had misused your power given your managerial position.

Ms Quinton-Carter outlined aggravating factors. She submitted that the aggravating factors include you having a lack of insight and reflection on the impact your conduct had on service users, which resulted in a direct risk to vulnerable patients.

Furthermore, Ms Quinton-Carter reminded the panel that it had found there was a risk of repetition and it was not sufficient for you to simply say that you would not act in a managerial role again.

Ms Quinton-Carter acknowledged that you have shown remorse during the proceedings, however noted the panel's findings that your remorse appeared to relate to the impact on you rather than on others.

Ms Quinton-Carter submitted that a striking off order would be appropriate and proportionate given the circumstances.

On your behalf, Mr Olphert reminded the panel that the purpose of imposing a sanction was not to punish you but to protect the public interest. He said there is a 'sanctions ladder' and the panel must work its way up from the bottom in deciding the appropriate sanction. He submitted that the cases showed that a finding of dishonesty did not automatically result in striking off.

Mr Olphert submitted that your dishonesty had been an isolated and spontaneous incident that occurred six years ago. It had not resulted in any personal financial gain. You had not been dishonest before the incident or subsequently.

Mr Olphert reminded the panel that you had worked as a registered nurse without incident since 2003 before this matter occurred. Before that you had worked in a care setting for a number of years. The NMC had placed no restrictions on your practise during the investigation.

Mr Olphert submitted that you have been placed in financial hardship by these proceedings and you are currently not in a financially secure position. He highlighted that since you started in the profession you have gone above and beyond for service users and the references from your colleagues supported this.

Mr Olphert submitted that it would be appropriate to impose a conditions of practice order with conditions that excluded the risk of you working in a managerial position and required you to reflect on your misconduct and its consequences for the service users.

Decision and reasons to correct error in submissions

Shortly after the panel retired, the parties' legal representatives agreed that an unintended error in Mr Olphert's closing submissions on the 18 July 2022 should be corrected, as follows.

> *While it is correct to say that there are no adverse findings recorded against Mr Hunt, the Registrant, there have been 2 prior referrals in, respectively, 2011 and 2015. In both cases it was considered that a finding of impairment was unlikely to be made and, therefore, the referrals progressed no further.*

Decision and reasons on sanction

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

SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features in respect of your misconduct other than that relating to dishonesty:

- Lack of insight into failings
- A pattern of misconduct over a period of time
- Conduct which put vulnerable patients at risk of suffering harm
- Your failure to raise the issues at the Home with the CQC and/or social services when you had been aware of them for a considerable period of time.

The panel also took into account the following mitigating features:

- Lack of support from the directors although this is somewhat tempered by your failure to alert other organisations as already mentioned.

The panel further considered the NMC guidance in relation to cases involving allegations of dishonesty. The panel found that the charges found proved of dishonesty were serious in that they involved

- Deliberate breach of the professional duty of candour by covering up things that have gone wrong…
- Vulnerable victims.
- Direct risk to patients.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the 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 your 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 nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public. The panel noted that merely restricting you from working in managerial position is also not workable. A registered nurse especially a senior registered nurse is likely to have what can be properly described as 'managerial responsibilities' without having the title of 'manager'. Your failure to reflect on your own capabilities and decision making as demonstrated in this hearing leads the panel to conclude that you are unsuited for any such role.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that a 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 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 breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

Accordingly, the panel determined 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?*

Your actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

The panel considered the element of dishonesty and was of the view that the conduct proved is of a serious nature. The panel accepts that your actions were opportunistic at the time rather than premeditated but were nonetheless a serious breach of candour and designed to cover up a serious failure by you. The panel found that the creation and production of the false risk assessment could have caused serious harm to the vulnerable patients in your care.

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 effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct yourself, 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 you in writing.

Decision and reasons on proceeding in the absence of Mr Hunt

When the panel delivered its decision on sanction Mr Hunt left the hearing. Despite attempts being made, including by his representative, to secure his reattendance, he did not do so.

In the circumstances, the panel considered whether it should proceed in the absence of Mr Hunt. It had regard to Rule 8 (6)(b) and heard the submissions of Ms Quinton-Carter who invited the panel to continue in the absence of Mr Hunt.

Ms Quinton-Carter submitted that Mr Hunt had voluntarily absented himself on the final day of the hearing and it is in the public's interest for the panel to proceed in his absence.

As he was without instructions, Mr Olphert made no submissions but remained to observe the remainder of the hearing.

The panel accepted the advice of the legal assessor.

The panel has decided to proceed in the absence of Mr Hunt. In reaching this decision, the panel has considered the submissions of Ms Quinton-Carter and the advice of the legal assessor. It noted that:

- No application for an adjournment has been made by Mr Hunt;
- Mr Hunt is fully aware that the hearing is ongoing but he has voluntarily absented himself;
- There is no reason to suppose that adjourning would secure his attendance in the near future; and
- There is a strong public interest in the expeditious disposal of the case, given the striking off order imposed.

In these circumstances, the panel has decided that it is fair and appropriate to proceed in the absence of Mr Hunt.

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 Mr Hunt's own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Quinton-Carter. She invited the panel to make an interim suspension order for 18 months to cover the appeal period. She submitted that this was necessary to protect the public and was in the public interest in light of the panel's findings.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the whole period as it will be inappropriate to allow Mr Hunt to work during this period.

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

That concludes this determination.