Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Thursday 31 August 2023

Virtual Hearing

Name of Registrant:	**Hyang Ja Teasdale**
NMC PIN	92A0162O
Part(s) of the register:	Registered Nurse – Sub part 1 Mental Health Nursing – 17 September 2005 Adult Nursing – 29 January 1992
Relevant Location:	Somerset
Type of case:	Misconduct
Panel members:	Dr Katharine Martyn (Chair, Registrant member) Mark Gibson (Registrant member) Tracy Stephenson (Lay member)
Legal Assessor:	Ben Stephenson
Hearings Coordinator:	Monsur Ali
Nursing and Midwifery Council:	Represented by Yusuf Segovia, Case Presenter
Mrs Teasdale:	Not present and not represented at the hearing
Consensual Panel Determination:	Accepted

Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12,13, 14, 15, 16, 17, 18 and 19
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Teasdale was not in attendance and that the Notice of Hearing letter had been sent to Mrs Teasdale's registered email address on 31 July 2023.

The Notice of Hearing letter had also been sent to Mrs Teasdale's representative Ms Crackett, on 31 July 2023. The panel had regard to the email evidence and a signed statement from an NMC case officer confirming this.

Mr Segovia, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

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

In light of all of the information available, the panel was satisfied that Mrs Teasdale has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34 of the Rules.

Decision and reasons on proceeding in the absence of Mrs Teasdale

The panel next considered whether it should proceed in the absence of Mrs Teasdale. It had regard to Rule 21 and heard the submissions of Mr Segovia, who invited the panel to continue in the absence of Mrs Teasdale.

Mr Segovia referred the panel to the email from Mrs Teasdale's legal representative dated 1 August 2023 which states:

> *'I can confirm that we have received the notice of CPD hearing and link. In accordance with the signed CPD agreement, Mrs Teasdale is not due to attend this hearing and I will be available via telephone (direct dial below) throughout the day in case any clarification or input are required on her behalf.'*

Mr Segovia submitted that Mrs Teasdale is aware of the hearing and had voluntarily absented herself and there was no reason to believe that an adjournment would secure her attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel decided to proceed in the absence of Mrs Teasdale. In reaching this decision, the panel considered the submissions of Mr Segovia and the advice of the legal assessor. It had particular regard to the overall interests of justice and fairness to all parties. It noted that:

- An application for adjournment has not been made by Mrs Teasdale;
- Mrs Teasdale, through her representative, informed the NMC that she has received the Notice of Hearing but will not be in attendance;
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

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

Details of charge

That you, a registered nurse and whilst employed as the Proprietor and/or Acting Home Manager and/or Registered Manager and/or Nominated Individual and/or Staff Nurse of Acacia Nursing Home (the Home), between September 2016 until November 2018:

1) Failed to ensure that the following CQC Regulations were being met at the time of an inspection on 7 and 8 June 2017;

a) Regulation 12 HSCA (Regulated Activities) Regulations 2014; Safe care and treatment; b) Regulation 17 HSCA (Regulated Activities) Regulations 2014; Good governance;

c) Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents;

2) Failed to ensure that the following CQC Regulations were being met at the time of an inspection on 14, 15 and 19 February 2018;

a) Regulation 18 CQC (Registration) Regulations 2009; Notifications of other incidents

b) Regulation 9 HSCA (Regulated Activities) Regulations 2014; Person centred care;

c) Regulation 12 HSCA (Regulated Activities) Regulations 2014; Safe care and treatment; d) Regulation 17 HSCA (Regulated Activities) Regulations 2014; Good governance;

e) Regulation 18 HSCA (Regulated Activities) Regulations 2014; Staffing

3) Failed to ensure that the following CQC Regulations were being met at the time of an inspection on 5, 6, 9 and 10 August 2018;

a) Regulation 9 HSCA (Regulated Activities) Regulations 2014; Person centred care;

b) Regulation 12 HSCA (Regulated Activities) Regulations 2014; Safe care and treatment; c) Regulation 17 HSCA (Regulated Activities) Regulations 2014; Good governance;

d) Regulation 18 HSCA (Regulated Activities) Regulations 2014; Staffing;

e) Regulation 18 of CQC (Registration) Regulations 2009 Notification of other incidents;

4) Failed to ensure that the following CQC Regulations were being met at the time of an inspection on 23 and 24 October 2018;

a) Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014; Safe care and treatment;

b) Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014; ensuring service users are safeguarded from abuse and improper treatment

c) Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014; ensuring systems and processes are effectively assessing, monitoring and mitigating risks relating to the health, safety and welfare of service users;

d) Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014; Staffing;

Infection Control

5) Between February and October 2018, did not ensure there were sufficient controls in place to manage and/or reduce the risk of infection, in that on one or more occasions:

a) Did not ensure that sufficient action was taken by members of staff;

b) Did not ensure there was adequate and/or sufficient cleaning equipment was provided and/or in place;

c) Did not ensure one or more areas of the Home were cleaned sufficiently by staff;

d) Were unaware how many residents were infected with Noro Virus;

e) Did not ensure accurate information was provided to Public Health England and/or Environmental Health Officer as to the number of service users and/or staff affected by the Noro Virus outbreak;

Pressure Sore Management

6) Between February and October 2018, did not ensure there were sufficient controls in place to appropriately manage pressure sore[s] in that on one or more occasions:

a) Did not ensure that pressure relieving mattresses were set correctly, as set out in Schedule A;

b) Did not ensure there was adequate and/or sufficient pressure relieving equipment in place;

c) Did not ensure that one or more residents were provided with the appropriate pressure relieving equipment, as set out in Schedule B;

d) Did not recognise and/or were unaware of the severity of one or more resident's pressure sore[s] as set out in Schedule C;

e) Did not ensure residents received sufficient care in respect of pressure sore risk and/or their pressure sore[s] as set out in Schedule D;

f) Did not recognise the grades of pressures sores for one or more residents as set out in Schedule E;

g) Did not ensure that one or more care plans contained sufficient information regarding pressure sore care and/or treatment and/or risk;

h) Did not ensure that one or more care plans contained sufficient information regarding the patient's pressure relieving mattress;

I) On concerns being raised with you in February 2018 by CQC Inspectors about incorrect pressure air mattress settings for one or more residents, did not ensure sufficient action was taken to correct this in a timely manner or alternatively, at all;

j) Did not ensure that accurate and/or sufficient information concerning the development of significant pressure ulcers were reported to the Local Authority at all or alternatively, in a timely manner;

7) In respect of Resident E, on one or more occasions between February and October 2018;

a) Did not ensure Resident E's pressure sore was appropriately maintained and/or did not deteriorate

b) Did not ensure his pressure mattress alarm was not muted/ on;

c) Did not ensure he had the appropriate pressure relieving mattress;

d) Did not ensure he had a call bell;

e) In August 2018, did not recognise that Resident E's pressure sore had deteriorated and had developed into necrosis;

f) Did not ensure that Resident E's care plan was accurate in that his pressure sore grade was not correct;

g) On an unknown date, removed Resident E's air mattress without clinical justification;

Medicine Management

8) Between December 2017 and October 2018, did not ensure that medicines were being safely managed in that on one or more occasions:

a) Did not ensure that the medicine fridge was properly maintained;

b) Did not ensure that medication was stored at the correct temperature in the medicine fridge;

c) Did not ensure that medicines were stored securely

d) Between February and August 2018, one or more medicines were left unattended;

e) Did not recognise the risk of choking and/or aspirating to patients in leaving Nutilis unattended in bedrooms;

f) In or around February 2018, did not ensure that medicines were ordered for one or more patients in a timely manner;

g) Did not ensure that medicine administration records were accurate for one or more patients as set out in Schedule F;

h) Did not ensure that medicines were appropriately prescribed and/or administered to one or more patients as set out in Schedule G;

i) Did not ensure that protocols for PRN medication were followed;

j) Did not ensure that medication was administered as prescribed;

k) Did not contact/consult the prescriber prior to the change in frequency of administration or at all;

Safeguarding

9) On one or more occasions, did not take sufficient and/or any action in respect of safeguarding incident[s]:

a) Did not ensure that any and/or sufficient action was taken following Resident F's fall and sustaining a head injury on 7 February 2018;

b) Did not carry out an investigation into how Resident E sustained his injury on 7 March 2018;

c) Did not make a record of the incident involving yourself and Resident A on 27 July 2018 in a timely manner or at all;

d) Did not ensure that following an incident involving Resident B relevant documentation was secured, which led to documentation being altered retrospectively

10) On one or more occasions, did not ensure that accurate and/or sufficient information concerning safeguarding incidents were reported to the Local Authority and/or Care Quality Commission in a timely manner or at all, as set out in Schedule H;

11) On one or more occasions, did not ensure residents were kept safe when serious allegations were made against members of staff in that;

a) Following an allegation on 14 September 2018 that Colleague A assaulted and made inappropriate comments to Resident C;

i) Colleague A returned to work prior to the conclusion of the Safeguarding investigation;

ii) Did not ensure that Colleague A was restricted from caring for Resident C;

iii) Did not take sufficient action on allegations against Colleague A being upheld at a disciplinary hearing on 17 October 2018;

b) Did not take any and/or sufficient action in respect of a member of staff who made inappropriate comments to Resident I;

12) Following Resident L's sexual assault on Resident M in or around February 2018;

a) Did not ensure that this incident was recorded in Resident L's care plan;

b) Did not recognise that this was a safeguarding incident which required reporting to the Local Authority

c) Did not ensure that the incident was formally reported to the Local Authority;

d) Did not ensure that this incident was investigated in a timely manner and/or at all;

e) Did not take any and/or sufficient action following the incident;

f) Did not ensure that Resident L was observed every 15 minutes and/or did not record these observations;

g) By August 2018, did not ensure that Resident L's care plan accurately reflected the risk posed;

Documentation and care

13) Did not ensure care plans contained sufficient information to accurately reflect the care and/or treatment and/or needs of one or more patients as set out in Schedule I;

14) Did not ensure patient records were kept up to date and/or accurately reflected risk and/or accidents and/or incidents for one or more patients, as set out in Schedule J;

Staff

15) Did not ensure that one or more members of staff received adequate training:

a) Induction training;
b) Infection control;
c) Safeguarding;
d) Epilepsy training;
e) Choking risks
f) Food suction machine;
g) Pressure care training;
h) Moving and Handling;

16) In October 2018, did not ensure that one or more members of staff received training to administer buccal midazolam to Resident G and Service User H

17) Between August and November 2018, on one or more occasions did not ensure that there were sufficient staff to care for residents in the Home;

Unprofessional behaviour

18) On 16 October 2018, you acted in an unprofessional manner in that you;

a) Shouted at Person A;

b) Pushed Person A on one or more occasions;

c) Your actions at the above charges were carried out in front of a resident and/or their family;

19) In July 2018, you did not respond appropriately to an incident involving Resident A in that you;

a) Restricted and/or held Resident A's arm;

b) Attempted to pull/push Resident A's clothes down;

c) Did not provide a privacy blanket/screen

d) Did not explain your actions to Resident A;

e) Did not use a distraction technique and/or provide reassurance to Resident A;

f) Declined to and/or did not disengage your hold from Resident A when you were asked to do so on one or more occasions;

g) Said in front of Resident A "this is how she gets", or words to that effect;

h) Your actions at the above charges were carried out in front of one or more residents and/or family members;

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

Schedule A

1. Resident F
2. Resident D

3. Resident C
4. Resident E

Schedule B

1. Resident H
2. Resident I
3. Resident G
4. Resident D
5. Resident E

Schedule C

1. Resident D
2. Resident C
3. Resident E

Schedule D

1. Resident C
2. Resident E
3. Resident D
4. Resident J

Schedule E

1. Resident C
2. Resident D

Schedule F

1. Service User A
2. Service User H
3. Service User G
4. Service User J

Schedule G

1. Service User G
2. Service User H
3. Service User I
4. Service User L
5. Service User M
6. Service User N

Schedule H

1. Resident E's injury on 7 March 2018:
2. Resident B's head injury in or around February 2018;
3. In or around October 2018, in respect of an alleged incident involving Colleague A and Resident C;
4. An alleged sexual assault by Resident L on Resident M on or around 6 or 7 December 2017;
5. Diarrhoea and vomiting outbreak;
6. Service User H's pressure ulcer in or around January 2018;
7. Service User G's pressure ulcer on 21 December 2017;
8. Service User G's facial bruising on or around 3 March 2018;
9. An incident involving Service User V and a relative on or around 10 May 2018;

Schedule I

1. Service User A
2. Service User B
3. Service User C
4. Service User D
5. Service User E
6. Service User F
7. Service User Q
8. Service User I
9. Resident K
10. Resident N

Schedule J

1. Service User B
2. Service User I
3. Service User P
4. Service User Q
5. Resident L
6. Resident P

Consensual Panel Determination

At the outset of this hearing, Mr Segovia informed the panel that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the NMC and Mrs Teasdale.

The agreement, which was put before the panel, sets out Mrs Teasdale's full admissions to the facts alleged in the charges, that her actions amounted to misconduct, and that her fitness to practise is currently impaired by reason of that misconduct. It is stated in the agreement that an appropriate sanction in this case would be a suspension order for a period of 12 months. It is further stated in the agreement that an interim order in this case was not necessary.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

'The Facts

1. *The facts are as follows:*

2. *Mrs Teasdale appears on the register of nurses, midwives and nursing associates maintained by the NMC as a registered nurse and has been on the NMC register since 29 January 1992.*

3. *On 28 January 2019 the NMC received an online referral from CB, Designated Nurse for Safeguarding Adults at the Somerset Clinical Commissioning group (the CCG) The CCG commissioned the care provided by Camelot Care, a company specialising in dementia care to the elderly. Camelot Care is owned by Mrs Teasdale and her husband JT.*

4. *Mrs Teasdale was named as the proprietor and director of Camelot Care along with JT who is not a registered nurse.*

5. *Camelot Care took ownership of Acacia Nursing Home (the Home) in September 2016 when it was rated as 'requires improvement' by the Care Quality Commission (the CQC). Mrs Teasdale was for a period the nominated individual from Camelot Care and the registered manager of the Home. She also, at times, worked as a registered nurse at the Home.*

6. *As part of the referral, CB advised the Home had closed in November 2018 under Mrs Teasdale and JT's ownership following a decision by the CCG and Somerset County Council to decommission the service. This decision was due to two inadequate inspection reports by the CQC and concerns the Home was unable to operate safely.*

7. *In June 2018 the CQC held the first inspection of the Home while it was owned by Mrs Teasdale and JT. Three further inspections took place in February 2018, August 2018 and October 2018. AG was the lead inspector for all four inspections completed at the Home.*

First Inspection June 2017

8. *The first inspection took place on the 7 and 8 June 2017. At that time there was a registered manager and operations manager in post however Mrs Teasdale remained the proprietor and director of the Home holding a degree of responsibility to ensure the safe running of the Home.*

9. *The CQC found that some residents were put at risk because their care plans and records were not kept up to date with changes and reviews which had occurred. For example, the CQC found five recent accidents recorded but all had an incomplete manager's section. One resident whose behaviour related to two of the*

incidents had a medicines review, but their care plan contained no information about this review.

10. *Additionally, three people at high or very high risk of pressure related wounds had not had their risks reviewed every month as the care plans instructed. Although risk assessments had been completed and reviewed as part of the transfer to an electronic care plan system, they did not include a printout of all the reviews and completed risk assessments which meant that the staff were unable to access the latest care residents had received. These failings were found by the CQC to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Charge 1) a))*

11. *The CQC also found breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on the basis the registered manager was not ensuring they followed the providers policies and procedures.*

12. *For example, the medicine policy stated that if a person had difficulty in swallowing medication the pharmacy should be contacted for advice. This did not happen for one resident during the inspection. By not following the provider's policies there were inconsistencies in the care and safety residents received (Charge 1) b))*

13. *Quality assurance systems in place to monitor care and plan ongoing improvements were also not always effective in identifying concerns and had failed to identify the concerns found by the CQC in relation to the risk assessments and care records. This meant that not all the concerns had been resolved by the registered manager to keep people safe and meet their care needs (Charge 1) b))*

14. *Finally, the Home had failed to notify the CQC of all significant events which had occurred in line with their legal responsibilities. Seven safeguarding alerts were reported to the Local Authority. Two recorded the CQC had been informed but the CQC found they had not been advised of any alerts. This was in breach of Regulation 18 of the Care and Quality Commission (Registration) Regulations 2009 (Charge 1) c))*

15. *In line with legal requirements following the inspection, on 27 August 2017 an action plan was submitted to the CQC by Mrs Teasdale in her role as acting manager and director (at that time) The action plan set out how each regulation the Home was in breach of would be met in the future.*

16. *Between the first inspection and February 2018 Mrs Teasdale was the acting manager except for one month when a new manager took up the post in January 2018.*

Second Inspection February 2018

17. *This inspection was originally due to take place in July 2018. The CQC made the decision to bring it forward in response to concerns raised by staff members, relatives and external healthcare professionals visiting the Home. The inspection was unannounced and took place on the 14, 15 and 19 February 2018.*

18. *At the time of the inspection Mrs Teasdale was the acting manager and had been since the 7 February 2018 after the resignation of the previous acting manager. Mrs Teasdale submitted notification of this to the CQC on 17 February 2018. The previous registered manager had resigned prior to the inspection.*

19. *This meant Mrs Teasdale held a substantial degree of responsibility, overseeing the running of the home and ensuring it was run in line with current legislation to keep residents safe and maintain a minimum standard of care. She was also the lead nurse supported by the deputy manager who was also a nurse.*

20. *The CQC found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Three of the breaches were repeated breaches from the previous inspection in June 2017 because of a failure to complete the actions included in the action plan and achieve compliance with the regulations (Charges 2) c) d) and f))*

21. *Additional breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were also found (Charge 2) b) and e)) as set out below.*

22. *During the inspection the CQC found that residents were not supported by enough staff to keep them safe and meet their needs in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Charge 2) e))*

23. *There were more residents who required individual support during mealtimes than staff available to support them. For example, one member of staff had to support three residents to eat their meals which took over half an hour.*

24. *During the inspection the CQC was told there were always two nurses on duty to complete the medicine round and support people with clinical issues. However, only one nurse was on shift and a senior member of staff completed the medicine round on the day of the inspection. The senior member of staff was not a nurse.*

25. *The rota showed there were other days when only one nurse was on shift and the inspector was given two different versions of a dependency tool used to determine how many staff were required to support people in the Home. This meant systems to identify staff levels and keep people safe were not consistently being used.*

26. *A breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and person-centred care was identified. People did not always have their care plans updated when their needs changed for example after a deterioration in their health.*

27. *People were not always supported to have a dignified death. Some people's care plans did not contain information about their needs and wishes for their end of life. By not having this information staff would not know if there was anything important to the person to support them prior to their death (Charge 2) b))*

28. *A continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 was identified. Notifications to other agencies had not always been made in line with current legislation to help monitor resident's safety and care. For example, two safeguarding alerts were sent retrospectively when the registered manager joined in January 2018. Mrs Teasdale was not aware a diarrhoea and vomiting outbreak in the Home at the time of the inspection was a notifiable incident because it could threaten the safe running of the Home. She was also unaware residents with significant pressure sores needed to be notified. Two residents with significant sores were identified during the inspection (Charge 2) a))*

29. *The Home was given an overall rating of inadequate and was put into special measures as a result. This meant the Home would be kept under review and*

inspected again within six months with an expectation significant improvement would be made within that time frame.

30. *After the inspection the CQC sent a notice of proposal under Section 26 of the Health and Social Care Act 2008 to Mrs Teasdale as the registered provider. The notice imposed conditions on Mrs Teasdale including not being able to admit new residents to the Home without the written agreement of the CQC and the need to carry out monthly audits assessing and mitigating a series of risks before sending the CQC monthly reports detailing the action taken.*

Third Inspection August 2018

31. *The third inspection of the Home took place unannounced on the 5, 6, 9 and 10 August 2018. During the inspection the CQC spoke with Mrs Teasdale and JT.*

32. *The CQC found there had been some improvements since the February 2018 inspection, most notably the Home's fire safety, but work had been completed by an external provider. The CQC had also referred their concerns to the Fire Service which the Fire Service had also followed up.*

33. *The CQC found Mrs Teasdale had failed to achieve compliance with regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Charges 3) a) to e))*

34. *At the time of the August 2018 inspection Mrs Teasdale was still the acting manager however a new manager had been identified and was in the early stages of the registration process with the CQC.*

35. *Mrs Teasdale was dependant on other members of staff to provide up to date information of resident's clinical needs despite being the acting manager. She was also unaware of concerns found around the Home including a muted alarm on a specialist air mattress and did not acknowledge the asphyxiation concern with this.*

36. *After the inspection a notice of proposal to vary a condition of Camelot Care's registration with the CQC was sent to the company. The CQC proposed to vary the condition authorising Camelot Care to carry on the regulated activity of treating disease, disorder or injury at the Home. The purpose of this condition was to lead to the slow closure of the Home while allowing one final chance to improve.*

Final Inspection October 2018

37. *The final inspection was prompted by multiple concerns received from relatives, staff and other healthcare professionals. The inspection took place unannounced on the 23 and 24 October 2018.*

38. *During this inspection the CQC only considered whether the Home was well led and safe due to the concerns received.*

39. *At the time of the inspection there was a new registered manager in place however Mrs Teasdale was still required to provide a monthly report to the CQC. There had been a delay in receiving the most recent report and this was provided during the inspection.*

40. *Poor communication was witnessed by the CQC during the inspection between the registered manager and Mrs Teasdale. For example, changing an air mattress for a resident with high risk of pressure ulcers without little explanation given to senior staff about this change.*

41. *Repeated breaches of regulations 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found and ongoing significant risks to resident's safety were identified (Charge 4) a) to d))*

42. *The CQC begun the process of urgently closing the home. A notice of enforcement action was sent to Camelot Care Limited seeking to cancel the Home's registration on the basis there was serious risk to a person's life, health and wellbeing. Residents were moved to other care homes. Mrs Teasdale did not challenge the CQC's enforcement decision and made the decision to close the Home.*

Specific Concerns at the Home

43. *Charges 5) to 18) relate to specific concerns witnessed by the CQC inspectors during the inspections completed in February, August and October 2018.*

Infection Control

44. *During the February 2018 inspection the CQC became aware there had been an outbreak of vomiting and diarrhoea in the Home and that residents were being looked after in their bedrooms to prevent the spread of infection (Charge 5))*

45. *The first reports of staff with vomiting and diarrhoea were recorded on 2 February 2018.*

46. *On 14 February 2018 during the inspection, AG spoke with an Environmental Health Officer (EHO) who was visiting the Home due to the outbreak. The EHO advised that deep cleaning should be carried out and residents, where possible, stay in their bedrooms.*

47. *Samples were not sent off for testing by the Home until it was raised by the Specialist Advisor Nurse who was part of the inspection team. AG witnessed uncovered bowls of hot food being taken into two bedrooms and a further six bowls of uncovered food was sitting in the dining room. This was a concern because as uncovered food cools down, the chances of bacteria growing in the food is increased. Also, the chances of cross contamination were increased by taking uncovered food into different rooms (Charge 5) a))*

48. *Cleaning staff at the Home were not provided with adequate equipment to reduce the spread of infection. On 15 February 2018, one member of staff was witnessed using a red mop and bucket to clean a communal area contrary to the colour coding for cleaning. The member of staff told the CQC this was because they didn't have any yellow equipment but according to the colour code a blue mop should have been used in communal areas and yellow mops were to be used when cleaning the bedrooms of residents with infections (Charge 5) b) and c))*

49. *AG met with the EHO on the 15 February 2018. A conference call took place with Public Health England (PHE) during the meeting when it became clear there was confusion about the number of residents who could potentially be affected and how many residents lived at the Home.*

50. *For example, PHE believed there were 41 residents living at the home as that is what Mrs Teasdale had told them, but the Home was only registered to accommodate 39 residents. PHE had also been informed the vomiting had stopped on 12 February 2018 but there were still residents affected during the inspection (Charge 5) e))*

51. *A list of all those affected was requested by the CQC at different points of the inspection to establish how many residents had been affected by the outbreak.*

52. *Mrs Teasdale provided the CQC with copies of four handwritten tables at different times. There did not appear to be any logical order to how matters were recorded or monitored. When spoken to on the 15 February 2018 about the issue, she was unable to tell the CQC an accurate number of residents and staff who had become ill during the outbreak (Charge 5) d))*

53. *On 6 August 2018 during the third inspection the CQC found further concerns in relation to there being sufficient controls in place to reduce and manage the spread of infection.*

54. *On 5 August 2018 at 14.08 hours the staff toilet was recorded as running out of soap. The cleaning check list was last filled out in June 2018.*

55. *On 6 August 2018 the CQC found a cleaning checklist for one bedroom had only been completed for five days in July 2018 and none in August 2018. Bedrooms were also found to be smelling strongly of urine in part of the Home (Charge 5) c))*

Pressure Sore Management

56. *On 14 February 2018 when questioned about the grades of pressure wounds of Residents C and D, Mrs Teasdale did not know the grades of the wounds of either resident. The specialist nurse advisor who was part of the inspection team later learnt Resident C had a grade 3 pressure sore on their heel and Resident D had a necrotic heal which meant the skin had started to die (Charge 6) f) and j))*

57. *During a conversation with the specialist nurse advisor later that same date, Mrs Teasdale was unable to confirm how many residents had pressure related wounds and how severe they were (Charge 6) d))*

58. *Concerns regarding pressure relieving air mattress settings were raised by the specialist advisor nurse during the February 2018 inspection.*

59. *On the 6 August 2018 the specialist advisor nurse found other mattress incorrectly set and the alarm being muted, putting residents at risk. This issue was raised by Mrs Teasdale on 6 August 2018 (Charge 6) i))*

60. *During the inspection on the 9 August, Resident E and C's pressure relieving mattress was found incorrectly set. The alarm was also muted on Resident E's mattress. When Mrs Teasdale was spoken to about this, she stated it was a specific member of senior staff who did the mattress audit but that member of staff was not a nurse and was supposedly managing the care agency run from the top floor offices of the Home (Charge 6) a) and 7) b))*

61. *On 10 August 2018 Residents G and H were found in wheelchairs with no pressure cushions when they were required. Resident H told AG he had 'burning on his bottom all the time' A member of staff confirmed the two residents had been sat for 45 minutes and that all the pressure cushions were in use (Charge 6 b) and c))*

62. *Shortly after this, a third resident, Resident I was found sitting in their bedroom in a wheelchair also without a pressure relieving cushion. Resident I told AG they wanted to stay in their room and got angry with staff when they suggested going downstairs. A member of staff confirmed Resident I should have had a pressure relieving cushion and be in their armchair if they were staying upstairs.*

63. *Mrs Teasdale came to speak with Resident I and repeatedly asked the resident if they wanted to go downstairs despite Resident I confirming they did not wish to. Mrs Teasdale did not identify there was no pressure relieving cushion in place. Shortly after a member of staff began taking Resident I downstairs and they changed their mind once they started moving. Mrs Teasdale initially confirmed to AG that Resident I should have a pressure relieving cushion in their chair but then stated they were not needed in wheelchairs as they were just for transfers (Charge 6) c))*

64. *On 10 August 2018 Mrs Teasdale told AG the Home was looking for more pressure cushions. During the final inspection she told AG they had only purchased another 10 cushions since the last inspection (Charge 6) b))*

65. *On the 23 October 2018 Resident E was found in their bedroom on a foam mattress rather than an air mattress. AG recalled the Resident had been on an air mattress during previous inspections due to high risk of pressure sores. At 10:46 hours while AG was with Resident E they called out for help but had no call bell. They were still calling out at 10:50 hours. A 10:52 hours a member of agency staff stated they were not aware if this was normal for Resident E however the Resident's care plan stated they may call out to express a need (Charge 7 a) c) d) f))*

66. *Mrs Teasdale was asked by AG at 11:04 hours about Resident E's mattress. She was unaware why it had changed and confirmed she did not think their needs had changed. The registered manager was also unable to tell AG when or why the mattress had changed. They both confirmed Resident E still had a pressure ulcer on their sacrum (Charge 7) g)).*

67. Resident E was found in the same position at 11:38 hours. At 11:41 hours Mrs Teasdale stated the resident was at high risk of pressure ulcers, that he moved a lot in the bed and urinated on an airwave mattress. Mrs Teasdale also stated there were no broken areas of skin on the resident's sacrum. AG was shown the air mattress checking sheet for the resident by Mrs Teasdale. This did not include Resident E despite them being at high risk of pressure ulcers.

68. Resident E's electronic care plan stated they were immobile and at risk of pressure damage due to this. They also contained records of a pressure wound which had broken skin in the sacrum area (Charge 7) e))

69. AG asked the registered manager (who was a nurse) whether she agreed with the record stating it was a grade one ulcer. She confirmed it was in fact a grade two pressure sore due to the broken skin. The resident's care plan stated there should have been an overlay mattress on their bed and the mattress settings should be checked daily but they did not record what the settings should be (Charge 7) f))

70. During a conversation with Mrs Teasdale, she could not say when the mattress had been removed (Charge 6) g) and h))

71. On the 24 October 2018 Resident was found on an air mattress in line with his care plan.

72. As the director, a registered nurse and at times the acting manager of the Home, Mrs Teasdale was responsible for the oversight of safe and effective care in relation to pressure area wounds. The absence of provision of correct equipment and delays in supporting residents to reposition can, and did lead to pain, skin damage

and discomfort. If left in unchecked, pressure damage can occur exposing bone which brings increased risk of sepsis and possible death.

Medicine Management

73. *During the inspection on 14 February 2018, a member of the CQC team who is a pharmacist provided feedback to Mrs Teasdale regarding concerns they had about medicine management after medicines were found in an unlocked cupboard under the sink in the treatment room. All staff at the Home had access to the treatment room including those untrained in medicine management and administration (Charge 8) c) d))*

74. *The inspection team also found medicines left in a basket on top of the medicine trolley and that the last temperature check completed for the medicine room where medication was stored, was in December 2017. Mrs Teasdale told AG this was the nurse's responsibility however no systems were found at management level to monitor whether this was being done.*

75. *Gaps were found in seven out of thirteen medicine administration records (MARS) which meant there was no record that residents were administered their medication correctly. Handwritten entries on the MARS did not have two signatures to confirm they were accurate. This meant there was a risk of entries being incorrectly recorded and residents not receiving the correct medication (Charge 8) g))*

76. *The temperature of the medicine's fridge was also found to be out of range. The recommended minimum temperature and maximum temperature is between 2 and 8 degree Celsius. The fridge was showing a maximum temperature of 13-degree*

Celsius meaning that medicines were being stored for days in temperatures far too high for the medicine being stored in it, including insulin.

77. *The effects of failing to maintain the correct temperature for fridges used to store medication is that the medication can lose its efficiency when not stored appropriately.*

78. *During a conversation with Mrs Teasdale, she stated that she believed the issue had been reported to Boots pharmacy but no evidence was produced to support this (Charge 8) a) b))*

79. *Mrs Teasdale was also asked about bisphosphonates medication which should have been administered to a resident once a week. Mrs Teasdale did not know what the medication was or who it was for and stated it was new and as such, had not been given to the resident. However, the medication should have been given to the resident on 11 February, 4 days before the inspection took place (Charge 8) f))*

80. *Ongoing concerns regarding medicine management were identified during the inspection on 6 August 2018. One of the concerns was about the use of antipsychotic medication being used regularly rather than used as PRN medication (medication not required on a regular basis)*

81. *It was explained to Mrs Teasdale why protocols for PRN medicines were important and using PRN medication regularly rather than as required was not appropriate unless the prescriber had been consulted. Throughout the conversations with Mrs Teasdale, she maintained it was down to the relatives insisting they used medications in that way. Mrs Teasdale was unable to show there had been any*

contact with other health care professionals or multi agency meetings to explore other options if they had disagreed with the views of relatives (Charge 8) i) to k))

82. *Further issues in relation to the medicine fridge temperature were also identified during the inspection on 6 August 2018. Although the temperatures were being recorded daily, when the temperatures were recorded above safe levels, no action was being taken (Charge 8) a))*

83. *One resident's records recorded that medication had not been administered because the member of staff was unable to locate the medication. This meant a potential risk of decline in health to the resident although no impact was seen to the resident during the inspection. Other concerns included that some medicines had not been administered to residents without a reason being recorded in their records and that prescribed medicines were running out for residents. Mrs Teasdale suggested this was the fault of the pharmacist and the GP however the systems in place at the Home should have flagged the issue before medicines ran out. (Charge 8) h))*

84. *Numerous tins of Nutilis (drink thickener) were found left unattended in residents' bedrooms meaning there was a risk of residents accidentally swallowing it and choking or aspirating. Mrs Teasdale stated they did this to encourage residents to drink at nighttime and lacked an understanding of the risk to residents in doing so (Charge 8) e))*

Safeguarding

85. *During the inspection on the 14 February 2018, accident and incident forms were found with no actions recorded as being taken. This included an incident which*

recorded Resident F had fallen and hit her head on 7 February 2018. No follow up actions were recorded, and no action taken despite a potential head injury (Charge 9) a))

86. *The management of the Home were responsible for sending statutory notifications to the CQC regarding safeguarding issues. This is to ensure external checks can be carried out. While reviewing the safeguarding folder during the inspections on the 5 August 2018 safeguarding incidents were recorded which should have been reported to the CQC but had not been (Charge 10))*

87. *For example, on 7 March 2018 Resident E had a haematoma to their left eye but did not match the list of notifications received by the CQC. The CQC shared their concerns with Mrs Teasdale during the inspection that there has been little investigation into this incident. Ms Teasdale stated the resident tended to hit themselves in the eye (Charge 9) b))*

88. *On 27 July 2018 an incident was witnessed by the Local Authority and CCG Safeguarding teams between Mrs Teasdale and Resident A.*

89. *During the inspection on the 6 August 2018 Mrs Teasdale was asked an account of the incident however she stated she could not recall it and confirmed she had not completed an incident record. Mrs Teasdale provided a written account on the 7 August 2018 (Charge 9) c))*

90. *The Local Authority received information that Resident B had sustained injuries including a severe head injury in the middle of the night during an unwitnessed incident in March 2018. The CCG and Somerset County Council jointly undertook an enquiry into the incident (Charge 9) d))*

91. One of the concerns raised was the lack of clarify of how Resident B's night care should be provided and whether bed rails should have been used. As the director and registered manager of the Home at that time, Mrs Teasdale was responsible for ensuring there as an appropriate care plan in place and securing all records as soon as possible after the incident.

92. However, the enquiry noted concerns that documentation provided had been altered retrospectively as some of the information had been overwritten (Charge 9) d))

93. During the inspection on 23 October 2018 the registered manager (not Mrs Teasdale) disclosed to AG an incident that took place on 14 September 2018 between a Healthcare Assistant (HCA) at the Home and Resident C. It was alleged the HCA had assaulted Resident C who suffers from dementia by poking her to the side of her face and telling her to 'shut up'.

94. Although the HCA was suspended and safeguarding referrals were sent to the Local Authority and CQC, the registered manager told AG Mrs Teasdale had allowed the HCA to return to work prior to the conclusion of the investigation and the disciplinary hearing.

95. At a disciplinary hearing on the 17 October 2018 the HCA was given a first written warning despite deciding that in 'all probability the allegation was true' (Charge 11) a) i) to iii)

96. During a conversation about other safeguarding allegations, Mrs Teasdale told AG that a male member of staff who was allegedly inappropriate with Resident I, was joking and it was the member of staff's 'way of talking' (Charge 11) b))

97. An incident involving alleged sexual touching of Resident M by Resident L which occurred at the Home in December 2017 (Charge 12) a) to g))

98. On the 25 January 2018 the care home manager (not Mrs Teasdale) sent a notification of the incident to the CQC. The notification highlighted that no safeguarding alert had been raised and the incident had not been recorded. A relative of Resident M was upset about the lack of action and had allegedly been told by Mrs Teasdale that she was mistaken about the incident.

99. During the inspection on the 14 February 2018 Mrs Teasdale was asked about this incident. She was unable to tell the CQC inspectors about the incident and referred the inspectors to two members of staff to confirm Resident L and Resident M's care plans had been updated.

100. On 6 August 2018 Resident L's care plan was checked during the inspection but there was nothing recorded in the records about the historic incident. This meant that new and agency members of staff may not have been aware of the incident (Charge 14))

101. Mrs Teasdale explained that staff continued to observe Resident L on an informal basis and Resident L's care plan contained conflicting information about how often he should be monitored which meant there was no clear guidance to staff on the issue.

Documentation and Care

102. Resident K had moved into the Home on the 7 February 2018. During the inspection on the 14 February 2018 Mrs Teasdale was unable to tell the CQC inspectors if Resident K had a care plan. Mrs Teasdale told the inspectors later

that day she had asked other members of staff to complete the care plan prior to Resident K's admission. Ms Teasdale did not produce a copy of the assessment despite leaving the room to get a copy.

103. A copy of the electronic care plan for Resident K was produced by a member of staff. The risk assessment was dated 14 February 2018 despite the inspectors being advised they had been completed on the 11 February 2018. The relatives of Resident K recalled a phone call with the Home prior to the resident's admission but did not recall an assessment (Charge 13))

104. On 14 February 2018, accident and incident forms were found during the inspection with no actions recorded as being taken. This included an incident form which recorded resident F fell and hit her head on the 7 February 2018. However no follow up actions were recorded despite the risk of a potential head injury (Charge 14))

105. During the inspection on the 5 August 2018 Resident N told the CQC inspectors that he wanted his body to be donated for medical research when he passed away. The resident's care plan did not contain any information about his wishes (Charge 13))

106. On 9 August 2018 the same resident told the CQC inspectors that a member of staff had put his compression socks on upside down and it was causing him pain. The resident's care plan was checked that same day but it did not contain any information about this (Charge 13)

107. Resident P had been hospitalised due to a seizure at the end of July 2018. During the inspection on the 6 August 2018, it was noted their care plan had not

been updated to reflect this new risk to them or that the potential risk was being monitored (Charge 14)

108. Resident G was at high risk of choking and reliant on assistance from staff at all times during mealtime. Despite AG observing two members of staff on 24 October 2018 assisting JM but not in accordance the clear instructions provided in JM's care plan. The care provided on that date was not recorded in the resident's care plan (Charge 13)

Staff

109. An up-to-date copy of the training matrix which recorded all staff training completed throughout the year was requested during the inspection in February 2018. This showed one member of staff had completed 19 training sessions using DVD's in one day. Having regard to the running time of the DVD's that member of staff would needed to have viewed them for at least fourteen hours without a break and did not allow for written checks of understanding to be completed following each DVD. Another member of staff had carried out their induction in the same manner in a single day (Charge 15) a))

110. During the inspection in February 2018 staff training in safeguarding and Mental Capacity Act 2005 (MCA) was found not to be met by the inspectors (Charge 15) c))

111. On 6 August 2018 a new concern was found for residents at risk of seizures including Resident P who was found asleep in another resident's bedroom on the first floor by the inspection team. No staff were available on the first floor. By being left alone on the first floor of the home there was a potential risk Resident P could

have a seizure without staff knowing and staff had not received any training any training in the subject. Three staff were unable to confirm what a seizure looked like when asked (Charge 15) d))

112. On 23 October 2018 at 14:49 hours a relative of Resident G told AG the resident still had food around their mouth. Resident G was at risk of choking and required his mouth to be cleaned after each meal to ensure food had not been pocketed in his cheek. At 15:09 hours the resident's mouth had still not been washed. At 15:14 hours two members of staff (a new agency staff member and one who had only been employed at the home for four weeks) came to clean the resident's mouth but neither had been trained to complete this task safely and the resident's relative had to show them.

113. Resident G also had a suction machine should they begin to choke or aspirate but staff had received no training to safely use this equipment. This meant the resident would not be supported safely if they started to choke on their food (Charge 15) e) and f))

114. On the 24 October 2018 a member of the cleaning staff found a soiled commode pan in the downstairs sluice room. The member of staff could not resolve this as they had never been shown how to use the sluice machine.

115. Relatives and staff spoken to during the inspections all commented there was not enough staff at the Home.

116. During the inspections in August and October 2018 it was identified by the CQC inspectors there was not enough staff to meet the resident's needs.

117. During the inspection on the 24 October 2018, it was established that there were many members of staff on shift who were not on the rota. Ms Teasdale was asked how she calculated staff levels at the Home. She was unable to say how she identified there were enough staff on duty or how she planned to ensure residents safe despite a high number of staff were planning to leave or had a leaving date (Charge 16)

Unprofessional Behaviour

118. CB directly observed Mrs Teasdale behave in an unprofessional manner towards JT in front of one resident and visiting relatives during a resident and family meeting which took place on 16 October 2018.

119. The purpose of the meeting was to advise families of residents the Home was closing. During the meeting JT made an inappropriate comment towards a family member in a loud and angry tone. Mrs Teasdale began shouting at JT and told him he could not say such a comment before she took hold of his arms and tried to push him backwards. The two ended up pushing each other two or three times in front of several family members and at least one resident. The incident ended when CB intervened (Charge 17))

120. As already stated at paragraphs 92 and 93 an incident was witnessed by members of the Local Authority and CCG safeguarding team on the 27 July 2018 between Mrs Teasdale and Resident A (who suffered from cognitive impairment)

121. It is alleged that Resident A began undressing her top half with her breasts exposed in the Lounge area where another resident and their family were also

sitting. Resident A was having difficulty removing her cardigan and became distressed.

122. Mrs Teasdale entered the room and began to pull Resident A's clothes down by restricting her arm and attempting to put her cardigan back on. Resident A became more frustrated and shouted 'no' several times. Resident A grabbed Mrs Teasdale's clothes but Mrs Teasdale failed to disengage her hold from Resident A. A social worker present asked Mrs Teasdale to step back but she declined and continued before allegedly saying 'this is how she gets it'.

123. There was no explanation from Mrs Teasdale to Resident A about what she was trying to do. Mrs Teasdale was asked to disengage for a second time and when she declined the social worker used a blocking technique across Mrs Teasdale chest causing her to disengage (Charge 18)

124. Mrs Teasdale did not display sensitivity or professionalism during her interactions with Resident A.

125. On the 17 March 2023 Mrs Teasdale's representative, Ms Crackett confirmed in emailed correspondence that Ms Teasdale admits all charges, that her conduct amounts to misconduct and her fitness to practise is currently impaired on both public protection and public interest grounds.

Misconduct

126. Mrs Teasdale admits the facts in this case amount to misconduct.

127. It is submitted that the comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 provide assistance when seeking to define misconduct:

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

128. The panel may further be assisted by the comments of Elias LJ in R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin) who stated that misconduct must be 'sufficiently serious that it can properly be described as misconduct going to fitness to practise'.

129. The NMC invites the panel to find that the facts amount to misconduct in that Mrs Teasdale's actions fell short of what would be proper in the circumstances.

The Code

130. Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) is, it is submitted, to be answered by reference to the Nursing and Midwifery Council's Code of Conduct.

131. It is submitted, that the following parts of the Code are engaged and have been breached by Mrs Teasdale:

1.Treat people as individuals and uphold their dignity

To achieve this, you must:

***1.1** treat people with kindness, respect and compassion*

1.2 *make sure you deliver the fundamentals of care effectively1.*
1.4 *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*

2.Listen to people and respond to their preferences and concerns
To achieve this, you must:
2.1 *work in partnership with people to make sure you deliver care effectively.*
2.2 *recognise and respect the contribution that people can make to their own health and wellbeing.*
2.6 *recognise when people are anxious or in distress and respond compassionately and politely.*

10 Keep clear and accurate records relevant to your practice.
To achieve this, you must:
10.1 *complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event.*
10.2 *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.*
10.3 *complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.*

14.Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place
To achieve this, you must:

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

14.2 *explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

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

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

To achieve this, you must:

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

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

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

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:

18.4 *take all steps to keep medicines stored securely.*

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

To achieve this, you must:

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

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

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

20 Uphold the reputation of your profession at all times.

To achieve this, you must:

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

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

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.

132. The CQC inspections revealed failings in the provision of care by the Home. Although the roles of the nominated individual proprietor, the manager and registered nursing staff all contributed to the safe and effective running of the Home, at times Mrs Teasdale functioned in all four of these roles.

133. Mrs Teasdale held responsibility as a decision maker in relation to staffing levels provided in the Home due to her role as director and manager. The CQC inspections noted how staffing levels were not adequate to keep people safe including the level of registered nursing care meaning that residents did not always receive safe care and treatment, and medicines were not managed safely. The decisions made in relation to staffing did not ensure the fundamentals of care were delivered effectively.

134. There were also occasions during the inspections when Mrs Teasdale was spoken to and did not appear to understand some basic principles of patient care including the management of pressure wounds.

135. In addition, Mrs Teasdale was observed using restrictive actions against a resident who suffered from cognitive impairment when alternative and less restrictive options were available and would have been less likely to have caused the resident being caused distress.

136. Mrs Teasdale, in all the circumstances of this case departed from good professional practice and the facts as accepted by Mrs Teasdale are sufficiently serious to constitute serious misconduct.

Impairment

137. Mrs Teasdale admits her fitness to practise is currently impaired by reason of her misconduct.

138. The NMC's guidance explains that impairment is not defined in legislation but is a matter for the Fitness to Practise Committee to decide. This involves a consideration of both the nature of the concern and the public interest.

139. The parties agree that consideration of the nature of the concern involves looking at the factors set out by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) by Cox J;

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 professions 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 professions; and/or*

d. *Has in the past acted dishonestly and/or is liable to act dishonestly in the future?*

140. It is submitted that questions a) to c) can be answered in the affirmative in this case.

141. During Mrs Teasdale's time as a registered nurse, manager and director of the Home, residents were put at unwarranted risk of harm.

142. The CQC inspection report completed in June 2017 concluded residents were not always kept safe at the Home because staff did not have access to the most recent records for some due to a transfer to electronic care plans. Risk assessments were carried out for residents but the ones used by staff were not always complete or did not contain the most up to date information meaning the care they received was not without minimum risk to them. Residents were not always protected from abuse because external agencies had not always been informed and actions taken had not been recorded.

143. The CQC inspection report completed in February 2018 concluded residents were not safe at the Home because they did not receive care and treatment in line with their health needs. There was a risk of infections spreading because the management at the Home did not have a clear system in place to manage infections and medicines were not managed safely. While staff understood how to recognise the signs of abuse and knew who to report it to, there were times action had not always been taken in a timely manner which meant residents were not always protected from potential harm. Recruitment procedures were not always followed to protect residents from unsuitable staff supporting them and there was not enough staff to meet residents needs and consistently keep them safe.

144. The CQC inspection report completed in August 2018 concluded residents remained unsafe at the Home because they did not receive care and treatment in line with their needs. There were risks of infections spreading because practices around the Home did not always keep it clean and medicines were still not managed safely. No training had been provided to staff in relation to residents

identified at risk of seizures and medicine competency checks for nurses had not been completed. Finally there was still not enough staff to consistently meet resident's needs and keep them safe from harm.

145. Although small improvements were identified at each inspection, by the final inspection in October 2018 concerns were still identified which placed residents at significant risk of harm or actual harm. Staffing levels were potentially dangerous at times including a high use of agency staff and there were periods of time when residents were not supported to keep them safe. Residents with specific health conditions were not having their needs met including pressure care and those at risk of seizures, or choking and aspiration. The management of the Home continued to fail to identify and improve the service residents received and alleviate the risk of harm.

146. The public has the right to expect a high standard of registered professionals. The seriousness of the misconduct is such that it calls into question Mrs Teasdale's professionalism in the workplace. This therefore has a negative impact on the reputation of the profession and, accordingly, has brought the profession into disrepute.

147. 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. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. Without it, patients and their families risk not putting their care into the hands of professionals and so risk their health and wellbeing.

148. Fundamental tenets of the profession cover the aspects of behavior, attitude and approach which underpin good nursing care. Registered professionals occupy a position of trust and must act to prioritise people, preserve their safety, practice effectively and promote professionalism. Mrs Teasdale can be said to have breached fundamental tenets of the profession by the very nature of the misconduct displayed in this case.

149. With regard to future risk, it may assist to consider the comments of ***Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin)*** *namely (i) whether the concerns are easily remediable; (ii) whether they have in fact been remedied; and (iii) whether they are highly unlikely to be repeated.*

150. The NMC's guidance entitled ***"Insight and strengthened practice (FTP-13)****" says the NMC should first consider if the concerns are capable of being addressed. The guidance states that a small number of concerns are so serious that it may be less easy for the nurse to put right the conduct.*

151. Ms Teasdale was ultimately responsible for the care of the residents in the Home as the director, registered manager and a registered nurse working at the Home. The level of care fell so far short of the standards the public expect of professionals caring for them and their loved ones that public confidence in the nursing profession could be undermined. The conduct occurred over a sustained period, despite repeated interactions and inspections by the CQC with the aim of improving the level of care at the Home. The failures were so serious that the Home was eventually closed by the CQC. This suggests an underlying attitudinal issue which is less likely to be addressed through remediation.

152. After the Home was closed Ms Teasdale and JT employed an operations manager with responsibility for the oversight of Camelot Care's three remaining nursing homes. The operations manager replaced Mrs Teasdale and JT as the nominated individuals for Camelot Care. Ms Teasdale's has not practised in a clinical capacity since October 2018 but remains the proprietor of the other three homes.

153. Mrs Teasdale demonstrated limited insight in her reflective piece dated 19 January 2022. Her reflective piece states that on reflection she considers 'we were trying to do too much too quickly and needed more support with the home'.

154. The reflective piece does not address the specific issues raised in the referral and inspection reports including matters such as safeguarding, not ensuring residents were kept safe when serious allegations were made against staff and the allegations that Mrs Teasdale herself was seen acting in an unprofessional matter. It also does not acknowledge the seriousness of the concerns or show any remorse for how vulnerable residents (who were moved from the Home) were failed.

155. Rather, the reflective piece focusses on how Mrs Teasdale took on too much too soon and made some improvements but was unable to improve standards at the Home. Consequently, it is not clear how Mrs Teasdale would do things differently in the future to demonstrate she has learned from her failings.

156. In the absence of sufficient insight, evidence of remediation in a clinical setting or evidenced steps she has taken to strengthen her practice to address these concerns, Mrs Teasdale is liable in the future to repeat the behaviour.

157. A finding of impairment is therefore necessary on public protection grounds.

158. *In Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) at paragraph 74 Cox J commented that:*

"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."

159. *Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and conduct and/ or to maintain public confidence in the profession.*

160. *In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right.*

161. *The NMC's guidance 'How we determine seriousness' states that a small number of concerns are so serious that it may be less easy for the professional to put right the problems in their practice which led to the incidents happening. Examples of such concerns include being directly responsible (such as through management of a service or setting) for exposing patients or service users to harm or neglect.*

162. Mrs Teasdale was directly responsible in her management position for the care of residents in the Home. The CQC inspections found substantial concerns in relation the standard of care provided which meant that residents were placed at significant risk of harm.

163. It follows the concerns in this case are so serious and more difficult to put right that a finding of impairment is required on public interest grounds to uphold proper professional standards and conduct and to maintain public confidence in the profession.

Sanction

*164. The proposed sanction in this case is a **12 month suspension order with review**.*

165. With regard to the NMC's sanctions guidance the following aspects have led to this conclusion:

166. The aggravating factors in this case included.

- *A pattern of misconduct over a period of time*
- *Conduct which put residents at risk of harm*
- *Limited insight, no remorse or remediation*
- *Previous regulatory proceedings similar for clinical failings and acting beyond scope of practice which resulted in 3 year caution order. This concerned 11 charges in November and December 2011 relating to the reduction and in some cases withdrawal of prescribed psychotropic drugs by*

Mrs Teasdale to elderly residents in a care home own part owned by her. Further, she amended two prescriptions before they were sent to the pharmacy. At the time of the charges, Mrs Teasdale was also the acting manager. The Caution order took effect on 7 August 2014, expired on 6 August 2017. Concerns were raised prior to the expiry of the caution order (at least June 2017).

167. The mitigating factors in this case included.

- *Made some limited changes to the services and care provided at the Home to address the specific areas of concern albeit unsuccessfully*
- *The Home was already assessed as requiring improvement when Mrs Teasdale took over as the proprietor*
- *The witness, CB describes Mrs Teasdale as working very hard and very long hours but that she had taken on took much and did not delegate*
- *Mrs Teasdale had responsibility for several positions at once*
- *A high staff turnover at the Home*

168. This case is not suitable for taking no action. It involves a series of concerns over a 16 month period which included conduct that put highly vulnerable residents patients at risk of harm (and ultimately led to the closure of the Home) as well as conduct which could undermine the public's trust in the profession. To take no action would go against the NMC's overarching objective of public protection, securing public trust in the profession and maintaining professional standards.

169. A caution order would not be appropriate on the basis the concerns involved a risk to the residents' safety and such an order would not provide sufficient protection the public given that it would allow Mrs Teasdale to continue to practise without any restriction.

170. The NMC's sanctions guidance states that a conditions of practice order may be appropriate when there is no evidence of harmful deep-seated personality or attitudinal problems; there are identifiable areas of the registered professionals practice in need of assessment and/or retraining; and conditions can be created that can be monitored and assessed.

171. The similar previous regulatory proceedings and caution order imposed which covered some of the same period as the current charges, as well as the fact the current charges occurred over a significant period of time despite escalation and monitoring by the CQC suggests there is evidence of attitudinal issues which means a conditions of practice order would not be appropriate.

172. After careful consideration, and having regard to proportionality, it is considered the most appropriate sanction is a suspension order.

173. In accordance with the NMC guidance this is a case which falls into the categories of serious concerns which are more difficult to put right, which could result in harm to patients if not put right and which are based on public confidence and professional standards.

174. Mrs Teasdale was directly responsible (through her management role at the Home) for exposing residents to risk of harm despite her professional duty to ensure they were safe. The incidents evidenced by the CQC are also so serious

they could affect the public's confidence in nurses. These factors mean the seriousness of the case requires temporary removal from the register and a period of suspension will be sufficient to protect patients, public confidence in nurses and professional standards.

175. The NMC's guidance on seriousness suggests that when considering this issue, the NMC will consider evidence of any relevant contextual factors. The Home was already assessed as requiring improvement at the time Mrs Teasdale and JT became proprietors. CB describes that she believed Mrs Teasdale had taken too much on, while also working very hard and long hours. When CB communicated this to Mrs Teasdale, Mrs Teasdale responded and brought in additional support, but this was either short in duration or the person had limited capacity.

176. Mrs Teasdale is … of age. In her reflection piece dated 19 January 2022 she expresses regret that she was not more successful in ensuring the safe and effective operation of the Home.. She also confirms she does not intend to return to practice and has held an administrative role in Camelot Care since the fitness to practice proceedings began.

177. Although the number and seriousness of the failings in the Home under the management of Mrs Teasdale raise fundamental questions about her professionalism (a key consideration that is taken into account when considering a striking-off order) Having regard to these contextual and mitigating factors, it is considered that a suspension order would still ensure the public is sufficiently protected and public confidence could still be maintained if Mrs Teasdale was not permanently removed from the register. Significantly Mrs Teasdale has engaged with her regulator and shown some, albeit limited insight into her misconduct. This

suggests that, while there are attitudinal problems, they are not so deep-seated as to be irremediable.

178. The NMC guidance on sanctions states that being proportionate means finding a fair balance between the nurse's rights and the NMC's overarching objective of public protection. The chosen sanction should not go further than necessary to meet this objective. As such, the parties consider that a striking off order would be disproportionate in a case where Mrs Teasdale has shown some insight and where the public is protected by the imposition of a suspension order.

In the circumstances a suspension order for the maximum period of 12 months is appropriate given the seriousness of the concerns and that residents were put a risk of harm. The NMC sanctions guidance states that such an order would usually be reviewed before its expiry and the parties agree that, due to the risk of the misconduct being repeated, and the consequent risk of harm to which patients would be exposed, the parties agree that in this case it is necessary and appropriate that the order is reviewed before its expiry.'

Here ends the provisional CPD agreement between the NMC and Mrs Teasdale. The provisional CPD agreement was signed by Mrs Teasdale on 12 July 2023 and the NMC on 14 July 2023.

Decision and reasons on the CPD

The panel decided to reject the initial CPD. The panel was considering imposing a sanction more restrictive than that proposed in the provisional agreement. Further, it was considering imposing an interim order. Following the NMC guidance FTP-DMA2B, the

panel had informed Mr Segovia and Ms Crackett of its intention. Ms Crackett has had the opportunity to consult Mrs Teasdale. Mr Sergovia's position, on behalf of the NMC, was neutral and Ms Crackett, on behalf of Mrs Teasdale, accepted that a more restrictive sanction would be accepted, as would an interim order.

The panel heard and accepted the legal assessor's advice. Mr Segovia referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. He reminded the panel that they could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Mrs Teasdale. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

Decision on facts

The panel noted that Mrs Teasdale admitted the facts of the charges. Accordingly, the panel was satisfied that the charges are found proved by way of Mrs Teasdale's admissions, as set out in the signed provisional CPD agreement.

Decision and reasons on misconduct and impairment

The panel then went on to consider whether Mrs Teasdale's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Mrs Teasdale, the panel has exercised its own independent judgement in reaching its decision on impairment.

The panel noted that Mrs Teasdale admitted that her actions amounted to misconduct. Furthermore, the panel determined that the concerns are serious and wide ranging which include clinical failures, poor leadership and management, and unsafe practice. Although, Mrs Teasdale expressed some insight into her misconduct, it is very limited and demonstrates a lack of understanding on the impact her misconduct had on the residents, the nursing profession and the public. The panel noted that there was actual harm caused to the vulnerable residents.

The panel therefore determined that Mrs Teasdale's actions fell far below the standards expected of a registered nurse. In this respect, the panel endorsed paragraphs 137 to 143 to of the provisional CPD agreement in respect of misconduct.

The panel furthered determined that Mrs Teasdale's misconduct brought the nursing profession into disrepute and breached fundamental tenets of the nursing profession. Moreover, the panel identified Mrs Teasdale breached further paragraphs of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code") in addition to those documented in the CPD agreement. These are as follows:

'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

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

8 Work cooperatively

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

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:

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

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

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

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice'

The panel then considered whether Mrs Teasdale's fitness to practise is currently impaired by reasons of misconduct. It noted that Mrs Teasdale accepts that her fitness to practise is currently impaired.

The panel determined that Mrs Teasdale's fitness to practise is currently impaired because there is no new evidence before the panel regarding what she had done to remediate the concerns or address the serious issues. It also determined that Mrs Teasdale's reflective piece dated 18 August 2022 demonstrated that she had not taken full responsibility for the failing in the Home and therefore there is likely to be a risk of repetition.

In this respect the panel endorsed paragraphs 148 to 160 and 168 to 169 of the provisional CPD agreement.

Decision and reasons on sanction

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

The panel took into account the aggravating and mitigating features identified in the CPD and in the panel's view the following aggravating and mitigating features apply:

Aggravating features:

- Mrs Teasdale knowingly took on the Home as proprietor when she knew it had been assessed as inadequate, and as an experienced care home owner

and nurse should have had in place a long term plan for its improvement and the maintenance of standards.

- A pattern of misconduct over a period of time.
- Conduct which put residents at risk of harm.
- The witness, CB describes Mrs Teasdale as working very hard and very long hours but that she had taken on took much and did not delegate.
- Previous regulatory proceedings similar for clinical failings and acting beyond scope of practice which resulted in a three year caution order. This concerned 11 charges in November and December 2011 relating to the reduction and in some cases withdrawal of prescribed psychotropic drugs by Mrs Teasdale to elderly residents in a care home own part owned by her. Further, she amended two prescriptions before they were sent to the pharmacy. At the time of the charges, Mrs Teasdale was also the acting manager. The Caution order took effect on 7 August 2014, expired on 6 August 2017. Concerns were raised prior to the expiry of the caution order (at least June 2017).

Mitigating features:

- Has admitted all the charges.

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 Mrs Teasdale's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Teasdale's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Teasdale's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the 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 Mrs Teasdale's registration would not adequately address the seriousness of this case and would not protect the public.

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

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

- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

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 Mrs Teasdale's actions is fundamentally incompatible with Mrs Teasdale remaining on the register.

In this particular case, 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?*

Mrs Teasdale's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register.

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

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

The panel determined 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.

Decision and reasons on interim order

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

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the

facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel in its determination had accepted the CPD, and due to the reasons already identified in the panel's determination for imposing the substantive order considered it would be appropriate and proportionate to impose an interim suspension order for a period of 18 months to cover the appeal period.

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

This decision will be confirmed to Mrs Teasdale in writing.

That concludes this determination.