Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Hearing
Monday 24 April – Tuesday 16 May 2023
Monday 21 August – Tuesday 22 August 2023 (in camera)
Monday 20 November 2023

Virtual Hearing

Name of Registrant:	Richard Khan Lall Mahomed
NMC PIN	69B0768E
Part(s) of the register:	Sub Part 1, Registered Nurse (16 March 2000) Sub Part 2, Registered Nurse (14 February 1969)
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	Patricia Dion Richardson (Chair, Lay member) Esther Craddock (Registrant member) Barry Greene (Lay member)
Legal Assessor:	John Bromley-Davenport KC
Hearings Coordinator:	Renee Melton-Klein Opeyemi Lawal (Monday 20 November 2023)
Nursing and Midwifery Council:	Represented by Unyime Davies, Case Presenter
Mr Mahomed:	Present and represented by Aparna Rao, (Royal College of Nursing)

No case to answer (Rule 24(7)):	7, 10, 11ai, 11aii, 11bi, 11bii, 13g, 13h, 13i, 14, 15c, 15d, 17c, 17h, 17i, 20, 22b
Facts proved by admission:	8a, 8b, 8c, 9a, 9b, 11c, 12, 13e, 15b, 16a, 16bi, 16bii, 16c, 17d, 17e, 17j, and 18a
Facts proved:	1a, 1c, 6, 13a, 13b, 13c, 13f, 15a, 17a, 17b, 17g, 19, 21a, 21b, 22a, 22d, 23
Facts not proved:	1b, 2a, 2b, 3a, 3b, 3c, 4, 5, 13d, 17f, 22c
Fitness to practise:	Impaired
Sanction:	Suspension Order (12 months with a review)
Interim order:	Interim suspension Order (18 months)

Details of charge

That you, a registered nurse and the managing director and registered provider of Ashley Down Nursing Home:

1. On or around 6 January 2020, in respect of Resident A
   (a) Documented that Resident A had been seen by a GP when she had not been seen by a GP
   (b) Failed to take the temperature of Resident A, a patient at risk of urosepsis, every 2 hours
   (c) Failed to monitor and/or document the vital signs of Resident A

2. And your conduct as specified in Charge 1 (a) was dishonest in that:
   (a) You knew that Resident A had not been seen by a GP
   (b) You intended to mislead person reading the progress notes into believing that Resident A's condition had been reviewed by a GP

3. Between October 2019 and February 2020, in respect of Resident B who had suffered a fall:
   (a) Failed to document the fall in the Resident's records and/or the incident record book
   (b) Failed to contact the Resident's GP in a timely manner or at all
   (c) Failed to take and/or record the Resident's vital signs

4. Between October 2019 and February 2020 failed to refer Residents C and D to the speech and language therapist, having been made aware of concerns regarding swallowing and/or a high risk of aspiration

5. Between October 2019 and February 2020 failed to contact the GP of Resident D with a view to changing a prescription of soluble paracetamol

6. Between October 2019 and February 2020 failed to ensure that Resident C received their regular prescription of Movicol in a timely manner

7. Between October 2019 and February 2020, in respect of Resident E, failed to ensure prompt administration of and/or documentation of the administration of, an aperient

8. Failed to administer and/or document the administration of medication in respect of an unknown resident on:
   (a) 8 December 2019 concerning a dietary supplement smoothie powder
   (b) 12 December 2019 concerning a dietary supplement smoothie powder
   (c) 15 December 2019 concerning sertraline

9. On 29 November 2019, in respect of an unknown resident, failed to
   (a) administer and/or document the administration of metformin
   (b) administer the correct amount of metformin

10. On or around 14 November 2019, in respect of an unknown resident, failed to obtain a second signature concerning a controlled drug namely a Butec seven-day patch

11. In respect of an unknown resident, failed to:
   (a) administer the correct amount of medication and/or failed to correctly document the amount of medication remaining on:
   (i) 5 November 2019
   (ii) 14 November 2019
   (b) administer the correct amount of medication on:
   (i) 10 November 2019
   (ii) 16 November 2019
   (c) sign for the administration of medication on one or more occasions on 19 November 2019

12. On 19 November 2019, in respect of an unknown resident, you failed to administer medication and/or failed to sign for the administration of medication

13. Between 2018 and May 2020 was reluctant to and/or failed to ensure that the Home had essential equipment available to be used, in good working order, namely:
    (a) a thermometer
    (b) a sphygmomanometer
    (c) an oxygen monitor
    (d) beds with the function to move up and down and/or with back rest function
    (e) shower chair
    (f) pressure mattresses
    (g) wipe pads and gloves of different sizes
    (h) personal protective equipment
    (i) a camera

14. In August 2019 instructed the Manager of the Home not to make referrals to the NMC in respect of 2 nurses and alleged medication errors

15. Between 1 January 2018 and May 2020 failed to encourage good nursing practice by:
    (a) Failing to take disciplinary action in relation to bad practice
    (b) Failing to actively promote safeguarding
    (c) Failing to implement an adequate complaints procedure
    (d) Failing to encourage transparency in dealings with residents or relatives of residents

16. Between 26 August 2019 and 12 May 2020
    (a) Failed to ensure that relevant checks were carried out when recruiting new staff
    (b) Failed to ensure the availability of staff records in relation to:
    (i) Disciplinary matters
    (ii) Induction

(c) Failed to ensure that staff were up-to-date with training and/or that accurate training records were being maintained

17. Between 2018 and March 2020 failed to ensure that systems and/or documentation were in place and available, concerning:
    (a) Evacuation plans for staff and visitors
    (b) Emergency contingency plan
    (c) Complaints policy
    (d) Audits
    (e) Action plans
    (f) Food stock ordering
    (g) Medication ordering
    (h) Short care plans for courses of antibiotics
    (i) The provision of pocket money to residents
    (j) Care plans

18. In or around May 2020 failed to ensure that:
    (a) Business insurance was put in place

19. Between February 2020 and June 2020 failed to encourage and/or discouraged the Manager to cooperate fully with the Care Quality Commission ("CQC") and the Kent County Council ("KCC")

20. Between 2015 and 2020 failed to ensure that the property and facilities were adequately maintained

21. On an unknown date said words to the effect of:
    (a) A staff member needed to be punched sometimes
    (b) Women needed to be punched sometimes

22. Between 6 February and 12 May 2020 failed to ensure that Ashley Down Nursing Home was able to provide a safe environment for residents in that:
    (a) The fire alarm system was not working and/or repaired in a timely manner

(b) Evacuation equipment was not in place and/or obtained in a timely manner

(c) There was not sufficient staffing levels to effect a safe evacuation

(d) The roof was leaking.

23. Between 2010 and 2020 failed to adequately lead and manage the Ashley Down Care Home

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

Decision and reasons on application of no case to answer

The panel considered an application from Ms Rao that there is no case to answer in respect of 1b, 1c, 7, 10, 11ai, 11aii, 11bi, 11bii, 13a, 13b, 13c, 13d, 13f,13g, 13h, 13hi, 14, 15a, 15c, 15d,17a,17c, 17f, 17g, 17h, 17i, 20, 22a, 22b, 22c, 22d. This application was made under Rule 24(7). This rule states:

> 24 (7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –
>
> (i) either upon the application of the registrant …
>
> the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

Ms Rao also set out the applicable test in R v Galbraith [1981] 1 WLR 1039 at 1042 and standard of proof required in R (Tutin) v. General Medical Council [2009] EWHC 553 (Admin) and R (Sharaf) v. General Medical Council [2013] EWHC 3332 (Admin) and Holroyde J in Soni v. General Medical Council [2015] EWHC 364 (Admin) at 61.

In relation to this application, Ms Rao submitted the following written submissions for each of the charges which are applied for in relation to there being no case to answer:

> *"1b: There are no patient records or medical diagnosis to show that this Resident required her temperature taken every 2 hours. There is no rota available. The NMC cannot prove that RM was working the relevant shift and it is unclear which shift that was. What evidence exists is tenuous and inconsistent. LS says (para 9) that she tried to take temp on Saturday. Her text message to RM at xp 7 states she told RM about the thermometer on Sunday. Without patient records RM cannot answer this allegation and it would be unjust to expect him to do so.*
>
> *1c: There are no patient records or medical diagnoses to show that additional observations were required for this particular Resident. The observation chart is absent from the witness's evidence. As above for 1(b), the NMC cannot prove that RM was working the relevant shift and it is unclear which shift that was. What evidence exists is tenuous and inconsistent. RM cannot answer this allegation and it would be unjust to expect him to do so.*
>
> *7: This charge relates to an unknown resident on an unknown date. No patient records have been provided. [Witness 1's] evidence was that she did not know if an aperient was already prescribed and/or available, nor did she herself administer an aperient. Further, [Witness 1's] could not explain why she did not administer an aperient upon observing that the patient had not opened her bowels. RM cannot answer this allegation and it would be unjust to expect him to do so.*
>
> *10: <u>Butec</u> (Buprenorphine) is a Schedule 3 controlled drug. Schedule 3 drugs do not need two signatures on administration. There is therefore no failure in the absence of a second signature where one is not required."*

She furthermore submitted from the Controlled drugs in care homes - Care Quality Commission (cqc.org.uk) :

"'You do not need to record schedule 3 drugs in the controlled drugs register. You must store certain schedule 3 drugs in the controlled drugs cupboard. This includes, for example, buprenorphine and temazepam.

There are other schedule 3 drugs that you do not need to store in the controlled drugs cupboard. Common examples include midazolam, pregabalin, gabapentin, tramadol and barbiturates (phenobarbitone).'

11ai: The signature ("FM") on the MAR chart for this date is not RM's. No error (if any exists) is attributable to him on this date.

11aii: There is no error on the MAR chart for this date. The entry is correct in all particulars. The count has been mis-recorded by the nurse FM on 5 Nov. Correct counting down from 56 (initial received quantity) gives a balance of 34 for 14 Nov.

11bi: This entry is correct in all particulars. The count has been mis-recorded by the nurse FM on 5 Nov. Correct counting down from 56 (initial received quantity) gives a balance of 42 for 10 Nov.

11bii: This entry is correct in all particulars. The count has been mis-recorded by the nurse FM on 5 Nov. Correct counting down from 56 (initial received quantity) gives a balance of 30 for 16 Nov.

13a: The evidence from the NMC's witnesses is that RM was informed on Sunday 6 Jan 2020 (xp7) and one was obtained the next day (Monday). There is nothing in this allegation.

13b: The evidence from the NMC's witnesses is that one was bought when it was asked for. There is no complaint at all here that needs to be answered.

13c: RM employed a RN who brought in a functioning OM until batteries were obtained for the existing one. The charge encompasses a lengthy period of time

during which there plainly was a working OM. It is unjust to expect the Registrant to answer this charge.

13d: The date(s) and identification of beds are vague and cannot be answered. It is unclear for how long this alleged situation persisted or why. It is also unclear whether patients were affected. There were functioning beds and replacement beds (the Home not being at capacity).

13f: There are no dates or details as to the complaint and the NMC's witness gave evidence that the correct mattresses were ordered, paid for, and arrived. RM cannot answer this allegation and it would be unjust to expect him to do so.

13g: The NMC's witness gave evidence that these were bought and available. There is no allegation to answer.

13h: The NMC's witness gave evidence that these were bought and available. There is no allegation to answer.

13hi: The NMC's witness gave evidence that a replacement charger was bought. There is no allegation to answer.

14: The NMC's witness stated, in answer to the Panel, that she was not so instructed. Her answer was that RM was not encouraging. It transpires that RM was right not to be encouraging of a referral to the NMC in respect of this conduct. When he did refer one of the nurses (LS) in January 2020 in respect of precisely the same errors identified by AI (plus several others), the NMC found that there was no need to investigate. There is nothing in this charge either factually or by way of criticism of RM's conduct.

15a: There is no evidence to support this charge. On the contrary, RM did take disciplinary action where necessary both himself and via his manager AI. The only provable example in the NMC's evidence is that of the alleged bad practice

of the nurses [Nurse 1] and [Witness 1]. When [Witness 1] was referred in 2020 the NMC decided not to take any action.

15c: Again, this is a vague and wide-ranging charge over a lengthy period of time without specificity to enable the Registrant to answer.
AI agreed that the complaints procedure existed electronically and in hard copy by the front door. She noted the hard copy been removed when she returned in March 2020. It was re-printed and re-attached.
The CQC report TW/1 xp53, and xp67 make it plain that in January 2020 there was an adequate complaints procedure in place. There is nothing in this charge.

15d: Again, this is a vague and wide-ranging charge over a lengthy period of time without specificity to enable the Registrant to answer. What evidence does exist shows that he and his staff were transparent with residents and relatives. The CQC report xp53, xp62-66, xp70, contains numerous reports of relatives and residents being satisfied with their treatment, communication, information, involvement, and care.

17a: AI agreed that an evacuation plan provided by Southern County Care was available. There is no evidence that plans were not available. Any hearsay evidence of other concerns is inconsistent with this evidence from the NMC's witness.

17c: AI agreed that the complaints procedure existed electronically and in hard copy by the front door. She noted it had been removed when she returned in March 2020. It was re-printed and re-attached.
The CQC report TW/1 xp53, and xp67 make it plain that in January 2020 there was an adequate complaints procedure in place

17f: Food was purchased on a regular basis and residents were fed. The CQC report indicates that meals were plentiful and appropriate (xp52 and xp62). Any other evidence to support this charge is inconsistent with the CQC finding.

17g: Medication was ordered and administered. The NMC's witness, AI, gave evidence of the procedures and systems in place for working with the surgery and pharmacy. She agreed there was a working computer, telephone, and internet access.

17h: AI gave evidence that there were template care plans for completion dependent upon the medication involved. There is no particularity to this complaint and it cannot be proved or answered.

17i: AI's evidence was that residents who had pocket money were able to utilise it. It was held either by the manager or by RM depending on the method by which it was sent to the Home by relatives. There is no complaint as to the provision of pocket money and no evidence that residents did not receive it or utilise it.

20: This charge is duplicative of other complaints within the allegations and is vague in the extreme. The Registrant cannot answer this and it would be unjust to expect him to do so. To ask him to answer this sweeping assertion is to seek from him evidence to make out the NMC's case. This is not his task. The NMC must by itself establish that there is a case to answer. It is submitted that, to the extent there is any such case to answer, it is dealt with in specific complaints in other charges and should properly be dealt with only in those charges.

22a: The evidence so far is that a contractor was engaged and paid to maintain and repair the fire alarm system whenever it was not working. The evidence is that staff on site could contact the contractor. When called out, contractor fulfilled its obligations in respect of repair. Where KFRS required action to be taken, it was taken. This included additional staff on site when the alarm system needed repair. There is no evidence that, to the extent it was not working or was damaged in some way, the system was not repaired in a timely manner.

22b: There is no coherent evidence of this. The witness AI confirmed in XX that all evacuation equipment was in place whenever she was working at the Home. In respect of the period she was not there, the KFRS and SCC documents at

xp162-184 indicate that some steps needed to be taken and these were duly taken. Importantly, the KFRS schedule at xp162-164 contains no complaint about evacuation equipment. To the extent that the witness SC gives inconsistent hearsay evidence about any other concerns/failures, her account is of little value in light of the documentary evidence, and should not be the sole or main ground on which the charge is proved.

22c: Again, the evidence is deficient. The staff levels were sufficient until 6 February 2020 when a repair was needed. That night, additional staff were on site as per KFRS requirements. The matter was repaid the following day. The KFRS schedule at xp162-164 contains no complaint about staffing levels. To the extent that other witnesses give inconsistent hearsay evidence about staffing, they should not be the sole or main ground on which the charge is proved.

22d: This sub-charge must be read in conjunction with the words at the start of the charge. The environment was not unsafe. The property required ongoing repair as would be expected for a listed building. Repairs were undertaken in order to keep the building functional and safe, as occurred on 6-7 February. Mere cosmetic objections, or individual preferences for expensive renovations, are irrelevant to this charge."

Ms Rao submitted that in taking the evidence at its highest there is either no evidence or it would be otherwise unsafe to find these charges proved. In these circumstances, it was submitted that these charges should not be allowed to remain before the panel.

Ms Davies invited the panel to find that there is a case to answer on all charges in this case. She submitted an evidence matrix to the panel, which outlines the NMC's evidence to the charges. She submitted that the panel's interpretation and understanding of the facts in this case is important, to assess the accuracy and clarity of the evidence. In response to Ms Rao's submission regarding the wording of the charges, Ms Davies submitted that these are not issues which should be addressed under an application of no case to answer.

Ms Davies submitted that, taking the evidence at its highest, there is sufficient evidence on these charges and there is a case to answer.

The panel accepted the advice of the legal assessor, who referred it to Rule 24(7) of the Rules.

The legal assessor advised that the NMC has brought these proceedings and it is for the NMC to prove its case. You are not required to disprove the allegations and no useful purpose would be served in continuing these proceedings if the panel is satisfied that, on the basis of the case which has been put before it, there is no real prospect of the NMC discharging that burden of proof. He advised that at this stage, the panel needs to decide whether the NMC has put evidence before it on all, or at least the key, elements of the charges in question which is sufficient to satisfy it that there is a case to answer and one which could justify proceeding further.

The legal assessor referred the panel to the two-limbed test laid out in *Galbraith*. In relation to these proceedings the test can be put as follows:

1. If there is no evidence against the registrant to support a particular charge then the case must be stopped in respect of that particular charge.
2. If there is tenuous evidence in that it is inherently weak or vague or inconsistent with other evidence and if the panel considers taking the NMC evidence at its highest that it could not properly find the particular charge to be proved on the balance of probabilities, then the case must be stopped as far as that particular charge is concerned. However, where the NMC's evidence is such that its strength or weakness depends on the view to be taken on a witness's reliability, or other matters which are generally speaking within the province of the panel, as judges of the facts, where on one possible view of the facts there is evidence on which the panel could properly come to the conclusion that a particular charge is proved, then the case should proceed.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether

sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

Charge 1b:

On or around 6 January 2020, in respect of Resident A

(b) Failed to take the temperature of Resident A, a patient at risk of urosepsis, every 2 hours

The panel considered that there was evidence capable of supporting this charge. The panel noted the discrepancy between the written statement of Witness 1 and the chronology set out in the letter to her manager exhibit LS 3. The panel was satisfied that this was an unintentional error, which affects the timeline of several of the charges. The panel closely examined the other documentary evidence to clarify this timeline. The panel concluded, on the basis of probability that: Witness 1 was on duty on 5 January 2020 (Sunday), you were on duty on 6 January 2020 (Monday), Witness 1 came back on duty 7 January (Tuesday) which is when she sent the letter to the Home manager, exhibit LS 3. Finally, the text message exchange, exhibit LS 2 occurred on 8 January 2020 (Wednesday). The panel concluded that as the letter was contemporaneous the error is most likely to be in Witness 1's statement to the NMC, which was dated 20 October 2020 . Given the corrected timeline above, with the dates corrected to coincide with the other evidence, the panel was satisfied that there was sufficient evidence on which the panel could find that you were the registered nurse on duty. Having considered the risk to Resident A and the medication prescribed to her, the panel was satisfied that they could find on the balance of probabilities that Resident A was known to be at risk of urosepsis.

The panel considered the documentary and oral evidence, noting the statement of Witness 1 and exhibits LS 1 and LS 3 and the dates that she was on duty in regard to the use of the thermometer. The panel also noted that in oral evidence Witness 1 stated that there were no patient records of observation charts used in the care Home and any observations would be recorded in the care plan, an extract of which is before the panel. The panel was of the view that there was evidence upon which the panel could properly come to the conclusion that you had a duty to take the temperature of Resident A at two

hourly intervals and that you had failed to do so. Accordingly, the panel found there was a case to answer.

Charge 1c

(c) Failed to monitor and/or document the vital signs of Resident A

Having decided in relation to Charge 1b that you were the registered nurse on duty, on the day referred to in the charge and having considered the oral evidence of Witness 1 and exhibit LS 3 in which the concern was escalated to the Home manager. The panel was of view that there was evidence upon which the panel could properly come to the conclusion that you had a duty to monitor and/or document the vital signs of Resident A and failed to do so. Accordingly, the panel determined there was a case to answer.

Charge 7

Between October 2019 and February 2020, in respect of Resident E, failed to ensure prompt administration of and/or documentation of the administration of, an aperient

The panel decided that there was no case to answer in regard to this charge. The panel noted that it did not have evidence as to who was on duty prior to Witness 1 coming on duty or evidence that demonstrates that you were on duty at that time or why, at the handover, it would have become your responsibility to administer the aperient. Furthermore, there is no clear evidence why Witness 1 did not administer the aperient whilst she was on duty. Additionally, there is no patient identification nor records to indicate the date of this charge. The panel was of the view that there was insufficient evidence that it could properly come to the conclusion that this charge could be proved. Accordingly, the panel determined there was no case to answer.

Charge 10

On or around 14 November 2019, in respect of an unknown resident, failed to obtain a second signature concerning a controlled drug namely a Butec seven-day patch

The panel considered the evidence of Witness 1 who indicated that it was the custom or practice to have two signatures in regard to Schedule 3 controlled drugs. The panel also considered the MAR chart in exhibit LS 3, which the witness stated indicated a requirement for a second signature. The panel considered the submission made by Ms Rao, who referred it to legislation which she suggested stated that two signatures were not required for Schedule 3 controlled drugs. The panel was not provided with any regulation that specifically stated whether or not two signatures were required for the administration of this particular Schedule 3 controlled drug.

The panel asked for further clarification from the NMC to understand what the requirement is in regard to Schedule 3 controlled drugs and what is the position of two signatures for the administration of Schedule 3 drugs at this institution. The panel heard that there was no further evidence in relation to this.

The panel concluded that there was insufficient evidence to determine if you had a duty to ensure that there were two signatures required for the administration of this Schedule 3 controlled drug. Accordingly, the panel found that there was no case to answer.

Charge 11ai:

In respect of an unknown resident, failed to:

(a) administer the correct amount of medication and/or failed to correctly document the amount of medication remaining on:

(i) 5 November 2019

Having considered the evidence, specifically the MAR chart dated 5 November 2019, which is exhibited in LS 4, the panel are not satisfied that it could find, in due course, that you were the person on duty at the time related to the charge.

The panel noted that the signature on the MAR chart appears to be FM rather RM, which the panel heard in oral evidence may have been an agency nurse. The panel also noted that there are discrepancies over a number of dates in the recording of the quantity of medication that had been administered. The panel was of the view that there was insufficient evidence on which it could properly come to the conclusion that this

charge could be proved. Accordingly, the panel determined there was no case to answer.

Charge 11aii

(ii) 14 November 2019

Having decided in Charge 11ai that there are discrepancies over a number of dates in the recording of the quantity of medication that had been administered, the panel concluded there is no evidence to demonstrate that the error in the medication count could be attributed to you and accordingly, the panel determined there was no case to answer.

Charge 11bi

(b) administer the correct amount of medication on:

(i) 10 November 2019

Having considered the discrepancies evident in the MAR chart 4 relating to the medication count from 5 November 2019 onwards, the panel determined that the medication count recorded by you on 10 November 2019 was the correct count for that date, given the adjustment from the initial error. The panel determined that there is not sufficient evidence to show that you made any errors in the administering of the medication on 10 November 2019 and found there is no case to answer in this charge.

Charge 11bii

(b) administer the correct amount of medication on:

(ii) 16 November 2019

Having considered the discrepancies evident in the MAR chart 4 relating to the medication count from 5 November 2019 onwards, the panel determined that the medication count recorded by you on 16 November 2019 was the correct count for that date, given the adjustment from the initial error. The panel determined that there is not sufficient evidence to show that you made any errors in the administering of the medication on 16 November 2019 and found there is no case to answer in this charge.

Charge 13a

Between 2018 and May 2020 was reluctant to and/or failed to ensure that the Home had essential equipment available to be used, in good working order, namely:

(a) a thermometer

The panel referred to the evidence of the timeline which it has established in relation to Charge 1b. It again noted the discrepancies in the statement of Witness 1 which do not correspond to the documentary evidence in exhibit LS 3, the panel gave greater weight to the documentary evidence in regard to the dates in question.

The panel is satisfied that there was a period of time that the staff in the Home did not have access to a working thermometer and that this could be seen as an essential piece of equipment that should be available at all times, bearing in mind the vulnerability of the residents. The panel also took into account a letter to Mr 1 (who was working in the Home as a procurement manager) informing him that equipment, including a thermometer, was not available or in working order. This is exhibited as AI 1.

The panel was of the view that there was sufficient evidence on which it could properly come to the conclusion that this charge could be proved. Accordingly, the panel determined there was a case to answer.

Charge 13b:

(b) a sphygmomanometer

The panel considered the evidence of Witness 1 that there was no working sphygmomanometer in the Home when it was required. It also considered the evidence of Witness 2 in which she states that there was no working blood pressure machine. These appear to be two separate incidents.

The panel considered the submission made by Ms Rao in relation to the broad time frame of the charge. The panel noted the evidence given by Witness 2 who states

clearly that the incident occurred when she returned to the Home in March 2020. Furthermore, the panel noted the evidence of Witness 1 which suggests a time frame of between October 2019 and January 2020, when Witness 1 was employed for a second time at the Home. The panel concluded that this was a clear timeframe in relation to the charge.

The panel was of the view that there was sufficient evidence on which it could properly come to the conclusion that you were the registered manager and that you had a duty to provide and ensure that essential equipment was in good working order. Accordingly, the panel determined there was a case to answer.

Charge 13c

(c) an oxygen monitor

There is written and oral evidence from both Witness 1 and Witness 2 indicating that there was not a working oximeter at the Home for a period of time. The panel considered that this was a vital piece of equipment that should be available in the Home at all times, as checking oxygen saturation of vulnerable residents is an important aspect of care.

The panel considered the evidence of Witness 1, who stated that the oximeter did not have batteries and used her own equipment. There is separate evidence provided by Witness 2 that when she returned to the Home in March 2020, there was no working oximeter. The panel was of the view that the evidence provides specific enough dates to consider the charge and found there was a case to answer.

Charge 13d

(d) beds with the function to move up and down and/or with back rest function

Having considered the evidence, the panel noted that vulnerable residents often need different types of multifunction bed and that not having these can lead to patient moving and handling difficulties. Witness 2 stated that the beds were broken, and no action was taken for weeks. As previously noted, there were two periods of time, namely between

October 2019 and January 2020 and March 2020, indicated from the evidence. The panel considered that this provided sufficient specificity to enable you to answer the charge.

The panel determined there was evidence from two separate witnesses and from two distinct time frames that beds were not in working order. The panel was of the view that given this, and the importance of having working equipment in the Home, there was a case to answer in regard to this charge.

Charge 13f

(f) pressure mattresses

The panel was of the view that pressure mattresses are essential equipment in a nursing Home with vulnerable residents. The panel noted the evidence given by Witness 2 that she had to order pressure mattresses and that in the intervening period staff were resorting to taking functional ones from other residents. This appears to demonstrate that they were essential and were not available for some time. The panel was of the view that, again, the dates provided by the witnesses were specific enough to enable you to answer the charge and accordingly there is a case to answer.

Charge 13g

(g) wipe pads and gloves of different sizes

The only evidence that the NMC provided in relation to this charge was in the statement of Witness 2. It is alleged in this evidence that you had complained about the staff using too many wipe pads and gloves. The evidence before the panel suggests that the supplies were purchased when requested. The panel was of the view that there was insufficient evidence on which it could properly come to the conclusion that this charge could be proved. Accordingly, the panel determined there was no case to answer.

Charge 13h

(h) personal protective equipment

In reviewing the evidence before it, the panel only found that you raised objection to the way Witness 2 was purchasing Personal Protective Equipment (PPE), namely that she wanted to purchase extra supplies. The panel understood from the evidence that there was PPE available and found that there was no case to answer in relation to this charge.

Charge 13i

(i) a camera

The panel was of the view that a camera was an essential piece of equipment in the Home. The panel noted the evidence given by Witness 2 that the camera charger was not working, however, she also stated in her written evidence that you offered another camera as a temporary measure. The panel found that there was no case to answer in relation to this charge.

Charge 14

In August 2019 instructed the Manager of the Home not to make referrals to the NMC in respect of 2 nurses and alleged medication errors

The panel considered both the evidence and wording of this charge. It noted that the Witness 2, in her oral evidence, said that you did not instruct her not to make referrals to the NMC in respect of 2 nurses regarding alleged medication errors. She said that she was 'encouraged' not to refer, in lieu of other measures.

The panel are not satisfied that there is evidence upon which you should answer the charge, as there is no evidence that you instructed the manager of the Home not to make referrals. The panel found there was no case to answer.

Charge 15a

Between 1 January 2018 and May 2020 failed to encourage good nursing practice by:

(a) Failing to take disciplinary action in relation to bad practice

The panel first noted that there were some similarities between this charge and Charge 14, however, were of the view that there was a difference between an NMC referral, as detailed in Charge 14, and other internal forms of disciplinary action that could have been taken. The panel considered the oral and written evidence of Witness 2, particularly in relation to you not considering disciplinary action in regard to incidents of poor practice. Accordingly, there was sufficient evidence for you to answer this charge.

Charge 15c

(c) Failing to implement an adequate complaints procedure

The panel considered the evidence of Witness 2 who stated upon her return to the Home in March 2020 the complaints policy was missing. The panel noted the evidence in the CQC report, exhibit TW 1, in which reference was made at the time of the inspection in January 2020 to a complaints procedure that was followed. The panel found that there was insufficient evidence upon which the panel could properly find this charge proved. Accordingly, the panel found there was no case to answer.

Charge 15d

(d) Failing to encourage transparency in dealings with residents or relatives of residents

The panel considered the evidence of Witness 2 who stated that you did not encourage transparency with residents and their relatives. The panel noted the evidence provided in the CQC report in which reference is made to proper investigation and response to complaints and the involvement in the planning and reviewing of care by relatives and representatives. The panel found that there was insufficient evidence upon which the panel could properly find this charge proved. Accordingly, the panel found there was no case to answer.

Charge 17a

Between 2018 and March 2020 failed to ensure that systems and/or documentation were in place and available, concerning:

(a) Evacuation plans for staff and visitors

The panel considered the written and oral evidence of Witness 2 and found that concerns regarding evacuation plans for staff and visitors were corroborated by the deficiencies identified in the reports of the Kent Fire and Rescue Service and the Kent County Council, both of which were provided to the panel. Accordingly, the panel found there was sufficient evidence for you to answer this charge.

Charge 17c

(c) Complaints policy

The panel considered the evidence of Witness 2 who in her written statement said that upon her return to the Home in March 2020, the complaints policy was missing. However, the panel noted that this was not corroborated by the CQC report which stated that:

'The provider had a complaints policy and process. Complaints were recorded, investigated, and responded to.'

The panel found that there was insufficient evidence upon which the panel could properly find this charge proved. Accordingly, the panel found there was no case to answer.

Charge 17f

(f) Food stock ordering

The panel considered the evidence of Witness 2 who in her written statement said that upon her return to the Home in March 2020, there was no food stock ordering system in place. The panel further considered the evidence of communications between Mr 1 and Witness 2, namely exhibits TW 3 and AI 1. The panel noted that the charge did not relate to whether meals were being provided. Accordingly, the panel found there was sufficient evidence for you to answer this charge.

Charge 17g

(g) Medication ordering

The panel considered the evidence of both Witness 1 and Witness 2 that a medication ordering system was not in place. The witnesses gave examples of incidents demonstrating the lack of a medication ordering system. Accordingly, the panel found there was sufficient evidence for you to answer this charge.

Charge 17h

(h) Short care plans for courses of antibiotics

The panel found that the only evidence provided by the NMC relating to the time frame of the charge is given by Witness 2 in her written statement. The panel considered this evidence to be vague and accordingly were not satisfied that there is a case for you to answer in regard to this charge.

Charge 17i

(i) The provision of pocket money to residents

The panel considered the written and oral evidence given by Witness 2 and while it noted that the witness stated in her written evidence that she had some concerns about residents' pocket money, there was no evidence provided to the panel to support the charge that residents did not receive their pocket money as required. Accordingly, the panel found there was insufficient evidence for you to answer this charge.

Charge 20

Between 2015 and 2020 failed to ensure that the property and facilities were adequately maintained

The panel was of the view that the only evidence that related to the care of the building was in relation to the maintenance of the roof and there was no evidence to demonstrate that there were any further issues relating to the property and facilities. Furthermore, there has been no evidence to define what is adequate nor what other maintenance issues there may have been. The panel did find evidence regarding the

maintenance of the roof but was of the view that this would be better addressed under Charge 22. The panel determined that there was no case to answer in regard to this charge.

Charge 22a

Between 6 February and 12 May 2020 failed to ensure that Ashley Down Nursing Home was able to provide a safe environment for residents in that:

(a) The fire alarm system was not working and/or repaired in a timely manner

The panel considered all the evidence before it and was satisfied that the alarm system was not working, and that the matter was only resolved after considerable external pressure was placed on you. The panel has taken note of the date of the charge and of the exhibits KC 1, SC 1, TW 3 and the evidence of Witness 3. The panel is of the view that there is sufficient evidence for you to answer this charge.

Charge 22b

(b) Evacuation equipment was not in place and/or obtained in a timely manner

The panel concluded that there is insufficient evidence to demonstrate that evacuation equipment was not in place. There is no evidence of any missing equipment aside from, the hearsay evidence of Witness 3 who stated that the Kent Fire and Rescue Service had concerns that evacuation equipment was not in place. This hearsay is not corroborated by the Kent Fire and Rescue Service report. Accordingly, the panel find in relation to the evacuation equipment being in place, that there is no case to answer.

Charge 22c

(c) There was not sufficient staffing levels to effect a safe evacuation

The panel considered whether there was evidence regarding sufficient staffing levels to effect a safe evacuation. It took into account the NMC witness statements from Witness 3 and the Kent Fire and Rescue Service report. The panel noted that whilst there was

sufficient staff made available on the night of 6-7 February 2020, at the insistence of the Kent Fire and Rescue Service, no such provision was made on the previous night. The panel noted that the staffing level was not the result of a previously agreed contingency plan. Accordingly, the panel is of the view that there is sufficient evidence for you to answer this charge.

Charge 22d

(d) The roof was leaking.

The panel considered the evidence of the leaking roof and determined there was considerable evidence to demonstrate that this was an ongoing concern between 6 February and 12 May 2020. The panel heard evidence that, as a result of the leaking roof, the fire alarm system was damaged, plaster was falling from the ceiling, and water was coming into the Home. Bearing in mind that this was a Home for vulnerable residents, the panel was satisfied that there was sufficient evidence for you to answer the charge of failing to provide a safe environment and determined there was a case to answer.

Applications Allowed

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it would find the facts of charges: 7, 10, 11ai, 11aii, 11bi, 11bii, 13g, 13h, 13i, 14, 15c, 15d, 17c, 17i, 20, 22b proved and found there was no case to answer.

Applications refused

The panel was of the view that there had been sufficient evidence to support the charges at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer in the following charges: 1b, 1c, 13a,13b, 13c, 13d, 13f, 15a, 17a, 17f, 17g, 22a, 22c, 22d. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Background

You were referred by a former employee on 28 January 2020 in relation to your role as the Registered Manager and Director of Ashley Down Nursing Home (the Home). The Home has since closed however you remain the Registered Manager and Director of Lyndhurst Nursing Home. The concerns of this case relate to failures to appropriately manage and lead the Home which resulted in placing vulnerable residents and staff at risk of serious harm.

You qualified as a nurse in 1969 and were admitted to the NMC register in March 2002. You purchased Ashley Down Nursing Home in 2004 and in October 2010 you registered with the Care Quality Control (CQC) as the provider. The Home has never been given a higher rating than 'requires improvements' by the CQC since its registration in 2010. Kent County Council (KCC) terminated their contract with Ashley Down Nursing Home in May 2020 and the Home was deregistered by the CQC in August 2020.

The regulatory concerns that have been brought to this hearing are regarding failure to appropriately manage and lead the Home. It is alleged that you attempted to cover up mistakes or blame others and falsely reported incidents and documented inaccurate information in patients' records. It is further alleged that you failed to adequately manage and keep in good working order the building, facilities, and medical equipment in the Home which compromised the care of vulnerable residents.

Decision and reasons on facts

At the midpoint of the hearing, the panel received written submissions from Ms Rao who informed the panel that you made admissions to the following charges:

8. Failed to administer and/or document the administration of medication in respect of an unknown resident on:
   (a) 8 December 2019 concerning a dietary supplement smoothie powder
   (b) 12 December 2019 concerning a dietary supplement smoothie powder

(c) 15 December 2019 concerning sertraline

9. On 29 November 2019, in respect of an unknown resident, failed to
(a) administer and/or document the administration of metformin
(b) administer the correct amount of metformin

11. In respect of an unknown resident, failed to:
(c) sign for the administration of medication on one or more occasions on 19 November 2019

12. On 19 November 2019, in respect of an unknown resident, you failed to administer medication and/or failed to sign for the administration of medication

13. Between 2018 and May 2020 was reluctant to and/or failed to ensure that the Home had essential equipment available to be used, in good working order, namely:
(e) shower chair

15. Between 1 January 2018 and May 2020 failed to encourage good nursing practice by:
(b) Failing to actively promote safeguarding

16. Between 26 August 2019 and 12 May 2020
(a) Failed to ensure that relevant checks were carried out when recruiting new staff
(b) Failed to ensure the availability of staff records in relation to:
(i) Disciplinary matters
(ii) Induction
(c) Failed to ensure that staff were up-to-date with training and/or that accurate training records were being maintained

17. Between 2018 and March 2020 failed to ensure that systems and/or documentation were in place and available, concerning:

(d) Audits

(e) Action plans

(j) Care plans

18. In or around May 2020 failed to ensure that:

(a) Business insurance was put in place

The panel accepted the wording, as to the qualified admissions made by you, through your representative and on that basis find Charges 8a, 8b, 8c, 9a, 9b, 11c, 12, 13e, 15b, 16a, 16bi, 16bii, 16c, 17d, 17e, 17j, and 18a proved.

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

- Witness 1: Registered nurse who worked at the Home for six weeks beginning in July 2019 and again from October 2019-January 2020

- Witness 2: Registered nurse who had worked in the Home since September 2013 (initially as a Health Care Assistant) eventually becoming the senior nurse and then the manager in 2018. Resigned in August 2019 but returned as the interim manager in March 2020.

- Witness 3: Locality Commissioner with the KCC. Completed a report following an inspection of the Home between 13 and 20 February 2020.

- Witness 4: Adult Social Care Inspector for the CQC. Was involved in the inspection at the Home on 22 and 23 January 2020

The panel also heard evidence from you under affirmation.

In reaching its decisions on the disputed facts, the panel took into account all the witness, oral, and documentary evidence in this case together with the submissions made by Ms Davies on behalf of the NMC and by Ms Rao on your behalf.

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

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

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

Charge 1a

On or around 6 January 2020, in respect of Resident A

(a) Documented that Resident A had been seen by a GP when she had not been seen by a GP

This charge is found proved.

The panel is satisfied that this charge is proved on the basis of the evidence of Witness 1 at exhibit LS 3 which is a letter from her to Ms 1, who was the manager of the Home at that time. In this letter, dated 7th January 2020, she expressed concerns that you had documented that a GP had visited Resident A, the previous day, whilst Witness

1 was not on duty, and stated that she believed this was a false statement as she did not believe that this had occurred. The panel noted that the conversation recounted by Witness 1 between her and Resident A is hearsay, however understood from both Witness 1's oral evidence and your own evidence that this resident had the mental capacity to communicate and articulate her views about her care. The panel also considered the hearsay evidence regarding a conversation with the GP surgery in the same letter, stating that no GP had attended Resident A. The panel heard oral evidence, which was accepted by you, that this resident historically did not like to be seen or examined by a GP.

During oral examination, the panel heard that you documented the GP visit as it was reported to you by another nurse, whose name you can no longer remember. In considering your evidence in relation to this issue the panel was concerned that you, despite having knowledge of Resident A's preference not to be seen by a GP, did not make further inquiries from this nurse regarding this visit. Furthermore, you made no inquiry as to who had called the GP, why a GP had attended, or why antibiotics had been advised. However, you did admit that you documented that there was a visit from a GP.

In all of the circumstances, the panel is satisfied on the balance of probabilities that this resident had not been seen by a GP and by documenting that Resident A had been seen by a GP when she had not, the panel found this charge proved.

Charge 1b

On or around 6 January 2020, in respect of Resident A

(b) Failed to take the temperature of Resident A, a patient at risk of urosepsis, every 2 hours

This charge is found NOT proved.

The panel considered the evidence provided by Witness 1 in relation to the health of Resident A, namely that this resident had been at risk of urosepsis. The panel also

noted your acceptance during oral evidence that you were aware, from the notes and having been informed, that there was a risk to this resident of urosepsis. The panel considered this evidence, together with the contents of the progress notes, exhibited at LS 1, which document that Resident A appears to have been unwell before and on 6 January 2020 and concluded that Resident A was at risk of urosepsis.

The panel then went on to consider whether you had a duty to monitor Resident A's temperature every two hours. The NMC evidence in relation to this two-hourly duty comes only from Witness 1, and when questioned she stated that this requirement comes from her experience and knowledge. The panel had no documentary evidence confirming that this was a requirement in the circumstances of a resident at risk of urosepsis. You, as a registered nurse, gave evidence that your assessment, having seen the resident and carried out a visual observation and having had a conversation with her, were of the view that there was no need for her temperature to be taken every two hours. The panel note that regular temperature monitoring was likely to be best practice, but in the absence of any documentary evidence to demonstrate that two hourly temperature monitor was a requirement, it could not find this charge, as worded, proved.

Charge 1c

On or around 6 January 2020, in respect of Resident A

(c) Failed to monitor and/or document the vital signs of Resident A

This charge is found proved.

As in Charge 1b, the panel considered the progress notes exhibited at LS 1 that Resident A was unwell. There was reference in those notes to antibiotics being suggested. You accepted, prior to going on shift, that you were informed that this resident was at risk of urosepsis. You also accepted in oral evidence that you believed that a doctor had been contacted in relation to this resident. However, you stated in oral evidence that you did not monitor and/or document the vital signs of Resident A. The panel determined there was a duty for a registered nurse to do so given the evidence and found this charge proved.

Charge 2a

And your conduct as specified in Charge 1 (a) was dishonest in that:

(a) You knew that Resident A had not been seen by a GP

This charge is found NOT proved.

The panel found this charge is not proved. It was mindful that it must take into account the state of mind and the belief of the registrant as to the facts, whether or not it is reasonable, and accepted your evidence that it was a genuinely held belief that Resident A had been seen by a GP. Whilst the panel found Charge 1a proved, it was not satisfied that your actions, in documenting that the Resident A had been seen by a GP, were dishonest.

The panel noted that it would have been reasonable for you to follow up on the information you were given in the light of the history of this resident, but the panel understood that this was not the test for dishonesty and accordingly found this charge not proved.

Charge 2b

And your conduct as specified in Charge 1 (a) was dishonest in that:

(b) You intended to mislead person reading the progress notes into believing that Resident A's condition had been reviewed by a GP

This charge is found NOT proved.

In light of the panel's finding in 2a, the panel also found 2b not proved.

Charge 3a

Between October 2019 and February 2020, in respect of Resident B who had suffered a fall:

(a) Failed to document the fall in the Resident's records and/or the incident record book

This charge is found NOT proved.

The panel considered the written evidence of Witness 1 in which she states that when she arrived at the Home for her shift, she was greeted by the health care assistant, who told her that Resident B had fallen. In oral evidence, Witness 1 states that she began her shift at 13:00. Though Witness 1 states in her evidence in chief that you were aware of the fall, the panel have heard no further evidence regarding this nor have the NMC provided evidence to demonstrate how Witness 1 knew you were aware that Resident B had fallen.

In oral evidence, you said that you only knew about the fall at 13:50, when you were finishing your shift early to go to an appointment. You said that under those circumstances it would have been the responsibility of Witness 1 to handle the duties required after a fall. The panel was of the view that had you known of the fall; you would have had a duty to document it in the Resident's records and/or the incident record book. The panel was of the view that the NMC had not shown that you knew about it before you were ending your shift and noted that Witness 1 told the panel that, as a result of learning of the fall, she completed a body map of Resident B, though this was not entered into evidence. The panel was of the view that as Witness 1 had taken on some of the responsibilities required it was likely, on a balance of probabilities, that you understood that Witness 1 had agreed to take responsibility to record the incident. The panel found on the balance of probabilities this charge not proved.

Charge 3b

Between October 2019 and February 2020, in respect of Resident B who had suffered a fall:

(b) Failed to contact the Resident's GP in a timely manner or at all

This charge is found NOT proved.

The panel found this charge not proved on the basis that, as in 3a, your duty to document the fall of Resident B had been delegated to the next registered nurse on

duty, in this case Witness 1. The panel found that the duty to complete all of the requirements was required of the nurse in charge, to whom the fall had been reported, and that this included contacting the GP. The panel noted in Witness 1's oral and written evidence that you had given her assurance that you would call the GP, however we also note the evidence in her statement regarding a conversation with you the following day in which she stated,

> *"The next [day] I asked Mr Mahomed about this and he blamed me and saying that I should have called the GP."*

The panel is of the view that this corroborates your account that you had delegated this duty to Witness 1 and that on the balance of probabilities, there may have been a miscommunication regarding the conversation about contacting the GP between you and Witness 1. Accordingly, the panel find this charge not proved.

Charge 3c

> *Between October 2019 and February 2020, in respect of Resident B who had suffered a fall:*
>
> *(c) Failed to take and/or record the Resident's vital signs*

This charge is found NOT proved.

The panel, in light of its decision in Charge 3a, note that there was a duty to record the Resident B's vital signs following the fall, however, the panel accept that the duty had been delegated and therefore found this charge not proved.

Charge 4

> *Between October 2019 and February 2020 failed to refer Residents C and D to the speech and language therapist, having been made aware of concerns regarding swallowing and/or a high risk of aspiration*

This charge is found NOT proved.

The panel was satisfied that you were aware of the concerns as you accepted in oral evidence that you were made aware of Witness 1's concerns regarding swallowing and aspiration risks of Residents C and D. The panel then considered whether it was your duty to refer these residents to the Speech and Language Therapy Team (SALT). The panel was of the view that it was the duty of the nurse who carried out the assessment of the resident and had the concern to make the referral to the GP or in an emergency to the SALT team regarding those concerns.

The panel considered the evidence of Witness 1, in which she stated that she did not have access to email, which you accept. She also stated that she believed that her manager (Ms 1) did not have access to email either. In relation to this point, the panel noted that there is no evidence to show that the Home manager did not have email access at this time. Witness 2, who had been the Home manager before and after this time, stated there she had no difficulties accessing email. The panel noted that Witness 1 was of the understanding that all referrals had to be done by you. However, this was denied by you and there was not further evidence provided by the NMC to demonstrate that this was the case.

The panel further noted in the evidence provided by you, that it was possible for referrals to be made by telephone and evidence was not provided by the NMC to suggest that this was not the case. Accordingly, the panel found under these circumstances that it was not your duty, having not made the assessment nor you having these concerns, to make the referral in regard to Residents C and D and found this charge not proved.

Charge 5

Between October 2019 and February 2020 failed to contact the GP of Resident D with a view to changing a prescription of soluble paracetamol

This charge is found NOT proved.

The panel considered the evidence given by Witness 1 in the form of a text message dated 11 December 2019 and exhibited as LS 2. Regarding this evidence, you said that

it was the responsibility of the registered nurse on shift, to contact the GP if there is a concern. The panel noted that Witness 1 raised this concern with you on a number of occasions and found that she had eventually contacted the palliative care team in order to make the referral to the GP to have the oral paracetamol changed from soluble to a suspension.

You, in your evidence, further state that you did not feel that this change was necessary and had spoken to other nurses who had cared for the resident, who similarly did not have this concern. In these circumstances, and in line with the decision in the proceeding charge, the panel concluded that you did not have a duty to contact the GP and find this charge not proved.

Charge 6

Between October 2019 and February 2020 failed to ensure that Resident C received their regular prescription of Movicol in a timely manner

This charge is found proved.

The panel is satisfied from the evidence of Witness 1 that Resident C did not receive their prescription in a timely manner. She states that she informed you and in your oral evidence you said that you recall her mentioning that more Movicol was needed for the Home.

Witness 1 stated that all referrals and prescriptions in the Home had to be ordered via email and by you. She told the panel that she did not have access to email and that Ms 1 also did not have email at this time. In contrast to the circumstances detailed in Charge 4, the panel found it is likely that Ms 1 did not have access to email at this time as she had started at the Home in November 2019, this time frame being corroborated by Witness 4. Witness 1 further stated that this request could not be made by telephone. On the basis of the evidence provided by the NMC, the panel was of the view that it was your duty to ensure Movical was available for use in the Home. Furthermore, having heard from you, the panel noted that you did not take any action to obtain this prescription, and found this charge proved on the balance of probabilities.

Charge 13a

Between 2018 and May 2020 was reluctant to and/or failed to ensure that the Home had essential equipment available to be used, in good working order, namely:

(a) a thermometer

This charge is found proved.

In considering this charge, the panel noted the evidence of both Witness `1 and Witness 2, both of whom state that there was not a working thermometer in the Home during the dates specified in the charges.

Witness 1 in exhibit LS 1 noted that the batteries of the thermometer had run out and she was unable to take the temperature of a resident. Further in a text message to you, exhibited in LS 2 Witness 1 again notes that the batteries of the thermometer were not working, in her oral evidence, she again refers to not having a working thermometer, and stated that there was no other thermometer available.

The panel noted that there was some inconsistency regarding the dates when Ms 1 purchased another thermometer, but you accept that there was not a working thermometer for a period of approximately 24 hours. In addition, the panel has considered the evidence of Witness 2 in the exhibit AI 1 that upon her return to the Home in March 2020, there was no working thermometer. The panel heard that you accept that it was your responsibility to provide equipment for the Home and ensure that it is in good working order. Accordingly, the panel concluded that you failed to ensure that the Home had a working thermometer and found this charge proved.

Charge 13b

Between 2018 and May 2020 was reluctant to and/or failed to ensure that the Home had essential equipment available to be used, in good working order, namely:

(b) a sphygmomanometer

This charge is found proved.

The panel found this charge proved on the basis of the written and oral evidence of Witness 1, in which she informed you that the sphygmomanometer was broken. The panel also took into account the statement of Witness 2 in which she states that when she returned to the Home as manager in March 2020, there was no blood pressure machine available. The panel also noted her reference to this equipment not working in her exhibit AI 1.

The panel noted your account in which you say that you were not aware of the sphygmomanometer being broken, because no one told you. You also said that there were two sphygmomanometers. You accepted in oral evidence that this was an essential piece of equipment but maintained that you were not aware that the sphygmomanometer was not working. You went on to suggest that Witness 1 and Witness 2 intentionally kept this information from you, and you queried why no other nurses had brought this to your attention. Witness 1 accepts that you replaced the equipment, however, there was a period of time when it was not working according to both Witness 1 and Witness 2.

The panel did not accept your suggestion that there was a link between these two witnesses in making this allegation. The panel noted that Witness 1 left the Home in January 2020 and Witness 2 did not return to work at the Home until March 2020.

Charge 13c

Between 2018 and May 2020 was reluctant to and/or failed to ensure that the Home had essential equipment available to be used, in good working order, namely:

(c) an oxygen monitor

This charge is found proved.

The panel found this proved on the basis of the evidence of Witness 1 and Witness 2. In her oral evidence Witness 1 said that there were a number of days before new batteries were provided. The panel noted the following from her written statement:

> *"The oxygen monitor wasn't working as the batteries had run out and I couldn't find batteries at the Home to replace them with. I told Mr Mahomed and he said he would bring batteries in the next day but he didn't. In the end I had to bring in my own oxygen monitor because the batteries in the Home's one weren't being replaced*."

Further, the panel noted the following from the written statement of Witness 2 in which she stated that:

> *"There was no working blood pressure machine and oximeter."*

You accept that Witness 1 did raise this with you but that Witness 2 did not. Accordingly, on the balance of probabilities the panel found that there were times in which there was not a working oxygen monitor in the Home and found this charge proved.

Charge 13d

> *Between 2018 and May 2020 was reluctant to and/or failed to ensure that the Home had essential equipment available to be used, in good working order, namely:*
>
> *(d) beds with the function to move up and down and/or with back rest function*

This charge is found NOT proved.

The panel was of the view that evidence had been given by the NMC witnesses that there were beds that were broken in the Home during this time. However, there was evidence before the panel that suggested there were more beds than residents, as the Home was under capacity, and that residents could be moved to other working beds. The panel concluded that no evidence had been provided by the NMC to prove on the

balance of probabilities that you failed to ensure that there were sufficient beds with this function given the number of residents in the Home during the period stated in this charge and accordingly found this charge not proved.

Charge 13f

Between 2018 and May 2020 was reluctant to and/or failed to ensure that the Home had essential equipment available to be used, in good working order, namely:

(f) pressure mattresses

This charge is found proved.

The panel considered the oral and written evidence of Witness 2. The panel heard that there were pressure mattresses that had to be disposed of and she had difficulty getting replacements.

In your oral evidence, you said that there were spare mattresses available, however in her oral evidence Witness 2 states that she had to take pressure mattresses from some residents to provide them to other residents for up to a week or two, due to there not being sufficient working mattresses available for use. The panel found Witness 2's evidence to be more reliable as she was the day to day working manager in the Home at the time and was of the view that she would have had better working knowledge of the issues. She stated:

"some of the pressure air mattresses weren't safe to be used due to infection control and being damaged."

The panel also heard that residents would spend long periods in their rooms during this time as it was during the Covid 19 pandemic. The panel found on the balance of probability that there were insufficient pressure mattresses in working condition at the Home and found this charge proved.

Charge 15a

Between 1 January 2018 and May 2020 failed to encourage good nursing practice by:

(a) Failing to take disciplinary action in relation to bad practice

This charge is found proved.

The panel considered the oral and written evidence of Witness 2. In her witness statement she says:

'I worked with Mr Mahomed for several years and he never believed in whistleblowing, raising safeguarding concerns, taking disciplinary action, or following the policies and procedures of the Home.'

In her oral evidence, she stated that you turned a blind eye to any bad practice by staff. The panel found that on the balance of probabilities that this was more likely than not to have occurred. The panel took into account that Witness 2 was a person that you trusted, and the panel was of the view that she was a reliable witness. The panel concluded that given everything before it, you had failed to take disciplinary action in relation to bad practice and found this charge proved.

Charge 17a

Between 2018 and March 2020 failed to ensure that systems and/or documentation were in place and available, concerning:

(a) Evacuation plans for staff and visitors

This charge is found proved.

The panel took into account the documentary evidence of the Kent Fire and Rescue Service (KFRS) which was exhibited at TW3:

"The responsible person must

a) establish & where necessary, give effect to appropriate procedures, including safety drills, to be followed in the event of serious & imminent danger to relevant person
b) nominate a sufficient number of competent persons to implement those procedures in so far they relate to the evacuation of relevant persons from the premise;…

2.1 Deficiency
The responsible person has failed to comply with this article by not implementing suitable emergency and fire evacuation procedures for their premises. The evacuation of residents when a fire occurs is the responsibility of staff and not of the fire and rescue service, they will rescue residents only if the pre-defined evacuation strategy has failed.

The panel also considered that Witness 2 in her oral and written evidence states that when she returned to the Home there were no written plans available, and she only received a plan after the failed fire inspection.

You accepted in your oral evidence that the printed fire notice had been taken down and was not there on 6 February 2020, when KFRS attended. Accordingly, the panel found on the balance of probabilities that evacuation plans for staff and visitors was not in place and found this charge proved.

Charge 17b

Between 2018 and March 2020 failed to ensure that systems and/or documentation were in place and available, concerning:
(b) Emergency contingency plan

This charge is found proved.

Witness 2 stated in her oral and written evidence that there was no contingency plan, which is corroborated by Witness 4 in her oral evidence, and that she had to create one. This is further corroborated in the CQC report.

The panel noted that you said that one was available, but on the balance of probabilities the panel determined that it was more likely than not that an emergency contingency plan was not in place and found this charge proved.

Charge 17f

Between 2018 and March 2020 failed to ensure that systems and/or documentation were in place and available, concerning:
(f) Food stock ordering

This charge is found NOT proved

The panel saw in emails from Witness 2 to Mr 1, exhibited at AI 1 that staff were concerned about ordering food for the Home:

"I am not sure how you want to implement and me to inform you, when you asked the staff to text to you anything that is needed, so everyone is texting you. If I do as well, you will have 2 requests.

I don't want to be disturbed by text messages every time when one item is needed.
Please advise how you want to be done and by who.

Both cook decided the shopping list for kitchen to come to me and me to send to you to avoid further accusations. Both must come at one agreement how much is used per week. I don't cook so I cannot decide how much per week.

You dealing with the kitchen budget, so you should give them clear guidance what you expect.

To many people to get involved, will not bring better outcome."

The panel also took into account the KCC report exhibited at SC1:

Concerns have been raised that the provider carries out the food shopping. This makes it difficult to menu plan and the chef and Home Manager would like more responsibility for this and there have been times that the Home have run out of the things the residents want / need and it has taken time to get new supplies.

The cook works 5 days a week, the carer's cook the other two days.

It was also reported that care staff can run out of the supplies they need.

The panel took in account, however, that the KCC report was hearsay evidence.

The panel also considered the CQC report which stated that residents and family members said the meals were plentiful and appropriate:

"People were supported to eat a healthy and balanced diet and were offered drinks throughout the day to keep hydrated. Meals looked appetising.

People were offered a range of fresh fruit and vegetables."

The panel took into account the oral evidence provided by you that you put in the orders for the fresh food and there was a system which included you, the cook, and a delivery company. The panel determined that the NMC had not provided sufficient evidence to determined that there was no food stock ordering system in place, as opposed to the system in place merely not being efficient. Accordingly, the panel found this charge not proved.

Charge 17g

Between 2018 and March 2020 failed to ensure that systems and/or documentation were in place and available, concerning:

(g) Medication ordering

This charge is found proved

The panel took into account the KCC medication check exhibited at SC 1 and the CQC report which stated:

> *"People's medicines were not consistently ordered on time to make sure they had enough medicine when they needed it. For example, on the second day of our inspection one person was due to have a new pain patch applied. There were none in stock. Staff had not followed up with the GP and local pharmacy to make sure it was delivered. Staff contacted the pharmacy during the inspection to arrange collection of the pain relief. As a result of a large number of agency nurses covering shifts the communication was poor.*
>
> *There was not a clear audit trail to show what medicines had been received."*

The panel also considered the written and oral evidence of Witness 2.

The panel has not been able to understand what, if any, medication ordering system was in place at the Home. Accordingly, the panel found on the balance of probability that there was not a proper system in place and found this charge proved.

Charge 19

> *Between February 2020 and June 2020 failed to encourage and/or discouraged the Manager to cooperate fully with the Care Quality Commission ("CQC") and the Kent County Council ("KCC")*

This charge is found proved

The panel considered the witness statement and oral evidence of Witness 2 in which she consistently stated that whilst you did not tell her to be untruthful to the CQC and KCC, you discouraged her from being fully transparent to both organisations by not providing them with the full picture of the state of affairs in the Home. The panel also

noted the evidence of Witness 4 who stated that there were often contradictions and conflicting information provided by you and Witness 2.

The panel heard in your oral evidence that Witness 2 was a transparent and trustworthy person, whom you trusted. The panel found Witness 2 to be a reliable witness on this issue and found on the balance of probabilities that you did fail to encourage and/or discouraged Witness 2 from fully cooperating with the CQC and the KCC and found this charge proved.

Charge 21a and Charge 21b

On an unknown date said words to the effect of:

(a) A staff member needed to be punched sometimes

(b) Women needed to be punched sometimes

This charge is found proved

The panel considered both limbs a) and b) together. The panel carefully considered the evidence of Witness 2 and found her to be a consistent and reliable witness who is able to give evidence relating to a specific incident in which these words were said by you.

The panel recognise this is out of character, but on the balance of probabilities on the evidence before it, the panel found limbs a) and b) both proved.

Charge 22a

Between 6 February and 12 May 2020 failed to ensure that Ashley Down Nursing Home was able to provide a safe environment for residents in that:

(a) The fire alarm system was not working and/or repaired in a timely manner

This charge is found proved

The panel carefully considered the date of the charge and whilst the panel was satisfied that the system was eventually repaired after 6 February 2020, the panel was of the view that for a period of time on that date the fire alarm system was not working and

therefore did not provide a safe environment for residents. The panel considered the following from a letter from the CQC dated 6 July 2020:

> *"Two weeks after the inspection, on 6 February 2020, the Commission was informed there were significant concerns about service users' safety due to problems with the fire system...This was due to a leak within the property impacting on the fire detection system. The nominated individual did not take action to address this. The Commission contacted Kent Fire and Rescue Service. The nominated individual was asked, on 7 February 2020, to provide the Commission with assurances service users would be safe in the event of an emergency. The nominated individual emailed the Commission at 18:09 hours on 7 February 2020 noting they would send this information by Sunday 9 February 2020. The nominated individual did not provide the Commission with a robust contingency plan or the additional information we requested in a timely way."*

The panel concluded on the balance of probabilities that the fire alarm system was not working at this time of this charge and found it proved.

Charge 22c

> *Between 6 February and 12 May 2020 failed to ensure that Ashley Down Nursing Home was able to provide a safe environment for residents in that:*
> *(c) There was not sufficient staffing levels to effect a safe evacuation*

This charge is found NOT proved

The panel carefully considered the KFRS report and could find no evidence to confirm what the staffing levels should have been and what the deficit was at the time. The panel noted the hearsay evidence of Witness 3 in which she reported concerns by the KFRS regarding staffing level, however the documentary evidence does not make reference to these concerns. Accordingly, the panel find this charge not proved.

Charge 22d

Between 6 February and 12 May 2020 failed to ensure that Ashley Down Nursing Home was able to provide a safe environment for residents in that:

(d) The roof was leaking.

This charge is found proved

The panel considered the evidence of Witness 2 who refers to there being leaks in the roof when she returned to the Home, which resulted in water coming through the ceilings in a couple of residents rooms as of March 2020. The panel also took into account the evidence of Witness 3 who attended the Home in February 2020 and gives evidence of leaks being present at the time of her visit. She specifically refers to being present with you and showing a leak in a resident's room, which you said you were unaware of at the time.

The panel heard evidence that the leak may also have caused damage to the fire alarm system. The panel noted in your evidence that the ceiling plaster was swollen as a result of the leak and your acceptance in cross examination that even a small amount of water on the floor can cause a slippery surface. The panel was of the view that this could cause an unsafe environment for vulnerable residents. In all the circumstances, the panel was satisfied that the leaks in the roof did cause an unsafe environment and found this charge proved.

Charge 23

Between 2010 and 2020 failed to adequately lead and manage the Ashley Down Care Home

This charge is found proved

After considering all of the evidence before it, particularly Witness 2 who stated:

"I worked with Mr Mahomed for several years and he never believed in whistleblowing, raising safeguarding concerns, taking disciplinary action, or following the policies and procedures of the Home."

The panel found this witness to be both trusted by you and a consistent witness. The panel also took note of the evidence of Witness 3 in relation to the communication between you and Ms 1, as well as the CQC report in which the Home never achieved a higher review than “needs improvement”. Further, the panel took into account the letter from the CQC dated 6 July 2020 which stated:

> *The nominated individual failed to provide the leadership, oversight and scrutiny to ensure service users receive a safe and good quality service. The nominated individual had not addressed shortfalls found at the last inspection on 13 December 2018. The nominated individual failed to operate robust and effective systems and processes to assess, monitor and improve the quality and safety of the services provided to ensure compliance with the regulations.*

Based on the evidence that was before it, the panel was of the view that there was also poor communication and a lack of teamwork which the panel considered to be essential components of good leadership and management. Accordingly, the panel concluded that you failed to adequately lead and manage the Ashley Down Care Home and found this charge proved.

Fitness to practise

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

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

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

Submissions on misconduct

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

Ms Davies invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2018) (the Code) in making its decision.

Ms Davies identified the specific, relevant standards where your actions amounted to misconduct. She submitted the following written submissions:

6. *Misconduct is considered to be conduct that falls short of what would be proper in the circumstances. It is not defined by the NMC rules and is potentially a very wide concept comprising any departure from good professional practice, whether or not, it is covered by the NMC standards. Not all breaches of NMC standards necessarily amount to misconduct.*

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

8. *Whilst the test for misconduct does not refer to 'serious' conduct, a level of seriousness is required.*

9. *Guidance on seriousness can be found in the case of Dr Nandi v General Medical Council [2004]*

   Mr Justice Collins, para 31: What amounts to professional misconduct has been considered by the Privy Council in a number of cases. I suppose perhaps the most recent observation is that of Lord Clyde in Rylands v General Medical Council [1999] Lloyd's Rep Med 139 at 149, where he described it as "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.

10. *In determining the question of misconduct and/or impairment, the panel is entitled to take into account a breach of the standards set out in the NMC Code ('The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' or other guidance or advice.*

11. *It is submitted that the registrant's actions amount to breaches of the NMC Code of Conduct para as set out in the matrix. The registrant's actions and omissions fell significantly short of the standards expected of a registered nurse, and that the actions and omissions amounted to breaches of the Code.*

12. *It is submitted that the registrants conduct amounts to misconduct and should be considered serious.*

13. *The registrants conduct or failings put residents and staff at risk of harm and therefore a serious departure from standards. For example:*

a) Not administering prescribed medication at the allocated time or not recording that medication has been administered causes risk of physical harm to vulnerable residents

b) Not carrying out due diligence when recruiting staff or maintaining training records could mean staff are employed who may not be appropriate or suitable to care for vulnerable people.

c) Not ensuring that health and safety checks are carried out could lead to an unsafe environment and poses serious risk of harm to residents and employees.

d) Inaccurate documentation and record keeping could cause carers at the home to not have a full picture of the care to be delivered to residents.

e) Staff not being able to access essential equipment could prevent them from delivering the care necessary to their residents, and to recognise deteriorating health.

f) Not providing a safe living environment puts vulnerable residents at risk of harm of physical injury.

The panel carefully considered the very comprehensive written submissions by Ms Rao, in which she set out the general principles regarding determining serious misconduct established in the case law. These submissions included a very detailed table setting out the potential breaches of the Code put forward by Ms Davies, for each of the charges found proved, why there was either not a breach of the specific Code or otherwise why the charges did not amount to serious misconduct.

Submissions on impairment

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

Ms Davies submitted the following written submissions:

14. *The purpose of fitness to practise proceedings is not to punish the registrant for past wrongdoings, but to protect the public or profession where a registrant's current fitness to practise is currently impaired. In reaching this decision, the panel can take into account the past wrongdoing, but it is also required to take into account other relevant factors, such as whether the conduct in question is easily remediable, whether it has been remedied and the likelihood of repetition. Therefore, it is a forward-looking test.*

15. *Impairment is not defined by legislation or the NMC Code.*

16. *Guidance for panels can be found by considered the judgment of Mrs Justice Cox in the case of CHRE v NMC and Grant in reaching its decision. In paragraph 74, she said:*

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

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

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

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

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

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

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

17. *It is submitted that limbs a, b, and c are engaged in this case.*

18. *When considering current impairment, the Panel can be assist by considering Cohen v GMC [2007] EWHC 581 (Admin). In this case the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:*

    1. Whether the conduct that led to the charge(s) is easily remediable

    2. Whether it has been remedied

    3.Whether it is highly unlikely to be repeated

19. *It is submitted that the Panel has no material evidence before it from the registrant in relation to insight, remediation or remorse. Whilst there has been some acceptable in the form of admissions these were made at a late stage and the registrant demonstrated insufficient insight at the fact-finding stage.*

20. *Further, since the time of the concerns, the registrant has not provided a reflective response to the concerns addressing the risk of repetition.*

21. *The registrant has provided limited evidence of training regarding some of the charges. However, the Panel has heard oral evidence that going to the registrant's thought processes at the relevant time. It is submitted that the registrant has not demonstrated an understanding of what he would do differently if in the same position again.*

22. *It is submitted that there is no evidence of remorse or steps the registrant has subsequently taken to change his practice or behaviour by for example mentoring, self-reflection or personal research.*

23. *It is submitted that there is a high risk of repetition, and a finding of impairment is required on the grounds of public interest.*

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

25. *It is submitted that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds his fitness to practice impaired on the grounds of public interest.*

26. *The panel is invited to find that the registrant's fitness to practise is currently impaired.*

Ms Rao submitted the following written submissions:

9. *In the event that serious misconduct is found, the Registrant submits that there is no current impairment.*

10. *The Panel will have a reference, training certificates, and medical records for Mr Mahomed's wife.*

11. *Insofar as repetition is said to be a concerned (NMC para 23), the Panel will have in mind that Mr Mahomed's ability to run a care home is the province of other regulatory bodies. His nursing practice itself is not the main subject of the NMC's apparent concerns.*

12. *The Registrant does not intend to return to practice and has therefore not completed any recent training or reflective work. While this is not itself an answer to impairment, it is a relevant consideration.*

13. *As far as late-stage admissions are concerned (NMC subs para 19), the Panel will take into consideration the complexity and the vagueness of the charges the Registrant was asked to answer, and the fact that a number of charges have been found not proved.*

14. *The Panel is respectfully invited to find that there is no serious misconduct and no impairment.*

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

Decision and reasons on misconduct

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

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

Prioritise people

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

Practise effectively

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

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

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

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

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

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

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

To achieve this, you must:

10.1 complete all records at the time or as soon as possible after an event…

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

To achieve this, you must:

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

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

Preserve Safety

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

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

To achieve this, you must:

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

Promote professionalism and trust

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

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

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first
25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel went on to discuss each of the charges found proved and considered what charges, if any, amounted to serious misconduct. The panel considered that your conduct as found proved in charges 1c, 6, 8, 9, 11c and 12 did amount to serious misconduct. The panel was of the view that individually these charges would not, in themselves, be considered serious. However, when taken together, the collective number of errors in administering or recording the administration of medication, in combination with the length of time over which the failures occurred, amounted to a serious failure of the fundamental tenets of nursing practice.

The panel was also of the view, that the failure to ensure that essential equipment was available to the Home at all times, systems for evacuation and staff recruitment and management processes were effective and that the Home was a safe environment for its vulnerable residents as detailed in charges 13-23 also amounted to serious misconduct.

Accordingly, the panel was of the view, in thoroughly reviewing the facts found proved, that serious fundamentals of nursing care were not being provided over time and that fellow professionals would find this deplorable. The panel concluded that a number of the charges amounted to serious misconduct and found that your actions did fall seriously short of the conduct and standards expected of a nurse.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

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

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

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

d) *….*

The panel concluded that the first three limbs are engaged in this case. The panel acknowledges that there was no evidence of actual harm however, finds that patients were put at risk of harm as a result of your misconduct. As such, your misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that your admissions to some of the charges represent some insight into the failings. However, the panel was of the view that during your oral evidence you provided little of note to further demonstrate your insight. The panel noted that on a number of occasions when questioned as to whether you accepted responsibility for some of the failings in the Home, you placed the blame to lack of staff supervision from the nursing management and repeatedly appeared to blame the registered manager and staff for the failures in the home. The panel was of the view that you were attempting to diminish your responsibility for the failings, despite the fact that you played a key role, as at some points you were the only registered nurse on duty and were also the registered manager of the Home as well as the registered

provider. The panel noted a brief admission from you when questioned whether any fault may lie with you, that ‘I would accept also my leadership’.

The panel concluded that without any reflective statements or anything further before it to demonstrate any further insight, you currently have limited insight.

The panel was of the view that the charges found proved are remediable. However, the pattern of behaviour that you have demonstrated in regard to running the Home indicated constant delays in taking action to address the issues at hand. The panel was of the view that it was only when issues reached a crisis point that you had been willing to take action, rather than taking proactive steps to fundamentally improve the service. The panel noted that there had been little evidence of actions that you had taken to improve the service and processes in the Home following feedback from a number of CQC inspections in which the Home had never been rated higher than ‘requiring improvement.’ The panel was of the view that there is very little evidence that you have remediated and accordingly there is a risk of repetition.

The panel considered the certificates provided by you which showed completion of a number of, what appear to be mandatory training courses, during 2019-2020. The panel noted that there was no evidence that you had completed any further training to demonstrate that you have strengthened your practice since the charges were brought by the NMC. Furthermore, the panel noted that the Fire Safety and Evacuation Training undertaken on 18 October 2019, which predated the issues identified by the KCC and Fire Service at the Home, does not appear to have assisted you in addressing the issues raised in relation to fire safety within the Home.

The panel took into account that you were experiencing family difficulties regarding the health and care of loved one at the time of these incidents. The panel noted Ms Rao’s submission that you do not wish to return to nursing. However, despite this, the panel is of the view that in all the circumstances there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel were of the view that failings identified at the Home whilst under your leadership, resulted in the Home having to close as a result of being unable to obtain the required insurance. The panel noted that the closure would have had a real impact on the wider community, especially staff, residents, and their families. The panel was informed that all of the residents in the Home were rehomed. The panel were of the view that a fully informed member of the public would be very concerned about the number of serious issues identified by the CQC and the length of time that these concerns were being monitored without improvement. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel determined that you could not, at this time, practise kindly, safely, and professionally and was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that your registration has been suspended.

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

Representations on sanction

The panel noted that at the outset of these proceedings the NMC had advised you that it would seek the imposition of a strike-off if it found your fitness to practise currently impaired. However, the NMC position changed to a Suspension order for 12 months with a review before the end of the order.

Ms Davies submitted that the original sanction bid was a strike-off order, however, that has now changed to a 12-month suspension order with a review before the order expires. Ms Davies submitted that this is the most appropriate sanction in light of the panel's finding.

Ms Davies took the panel through the other available sanctions:

- Taking no action and Caution order: due to the seriousness of the misconduct applying these sanctions would be inadequate to deal with the concerns and will neither protect the public nor address the public interest.
- Conditions of Practice Order: patients would be put in danger as there is a high risk of repetition, that would remain despite the conditions. The CQC gave multiple opportunities to address the concerns raised in the report, but you did not take the opportunity this provided.
- Strike – off Order: The concerns found proved are remediable.

Ms Davies further submitted that in order to protect the public and to maintain public confidence, the appropriate sanction is one of a 12-month suspension order with a review.

Ms Rao agreed with the NMC's position on sanction.

Ms Rao submitted that imposing a condition of practice will be of no assistance because you do not wish to return to practice and have not worked for a number of years since the concerns were raised against you.

Ms Rao submitted that you wish to leave the profession with some dignity and a strike-off order will not allow you to do so.

Ms Rao did not oppose the NMC sanction bid of a 12-month suspension order as there will be no risk to the public.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Developing but, limited insight
- Pattern of misconduct over a period of time
- Conduct which put vulnerable residents at unwarranted risk of harm

The panel also took into account the following mitigating features:

- Engagement with the NMC process
- Early admissions to some of the charges
- Personal mitigation in relation to your family circumstances

The panel also took into consideration your reflective piece and your 40-year nursing career during which you had no previous regulatory concerns raised against you.

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 taking no action would neither protect the public nor be in the public interest.

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

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*

The panel is of the view that having found that your conduct is remediable there is no evidence that you have made efforts to remediate by strengthening your practice. You have not worked as a nurse since 2020 and have during the course of this hearing decided to retire from the nursing profession. In all of your current circumstances the panel was of the view that there is no evidence to suggest that you wish to engage with conditions to support your remediation such as retraining. The panel determined that in all the circumstances there are no realistic, practical or workable conditions that could be formulated to address the concerns that led to the finding of current impairment and protect the public. Accordingly, the panel determined that a conditions of practice order will not be appropriate.

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:

- *No evidence of harmful deep-seated personality or attitudinal problems*
- *No evidence of repetition of behaviour since the referral to the NMC*
- *There is evidence of insight and the registrant does not pose a significant risk of repeating the behaviour.*

The panel considered the submissions made on your behalf in relation to the distinction between 'clinical errors' and 'managerial errors'. The panel was of the view that both types of errors were of equal seriousness and noted that the 'managerial errors' found proved resulted in other nursing professionals being prevented from caring for the residents to the standard required.

Nevertheless, the panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be appropriate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction to mark the seriousness. Whilst the panel acknowledges that a suspension order may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Your attendance and engagement at the hearing
- Evidence of your current employment status
- In the event that you decide to return to nursing practice a further reflective piece demonstrating your insight, remediation and how you have strengthened your practice.

This will be confirmed to you in writing.

Interim order

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

Representations on interim order

Ms Davies submitted that an interim suspension order is appropriate to cover the appeal period, on the grounds of public protection and public interest for the period of 18 months.

Ms Rao did not oppose this application.

Decision and reasons on interim order

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

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

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

That concludes this determination.