

## **Fitness to Practise Panel Determination**

The following case was heard by a Fitness to Practise Panel. It is presented here to give an example of one possible outcome of breaching a principle in *Good Medical Practice*. It is not intended to give a clear threshold between acceptable and unacceptable behaviour. Each case which comes before a Fitness to Practise Panel is judged on its own merits and assessed on the particular circumstances of the case.

### **Summary**

The doctor was Director of a company which owned a nursing home. The doctor failed to provide adequate levels of staff, supplies, equipment, food and drink for the residents of her nursing home. As a result, the residents of the home received inadequate care.

### **Relevant paragraphs of *Good Medical Practice***

The case relates to the *Working with colleagues* section of GMP, specifically paragraphs 41, 41a-c and 42 on working in teams and paragraph 54 on delegation. It also relates to the *Probity* section, specifically paragraph 75 on conflicts of interest.

### **Determination on impaired fitness to practise**

“Miss Y

The Panel has considered on the basis of the allegations found proved, whether Dr X's fitness to practise is impaired pursuant to Section 35C (2) (a) of the Medical Act 1983, as amended, by reason of her misconduct. In so doing, the Panel has considered all of the evidence presented to it including the live evidence from 17 witnesses whom it had the opportunity to question closely, the facts found proved and your submissions on behalf of the General Medical Council.

The Panel has also borne in mind the advice of the Legal Assessor which set out the basis upon which this issue is to be determined. In particular he drew the Panel's attention to the recent case of *Harry v GMC* [2006] EWHC 3050 (Admin) in which Goldring J stated that in reaching its determination on the impairment of a doctor's fitness to practise, the Panel must first determine whether there has been misconduct and, if so, it must go on to ask itself whether that misconduct has impaired the doctor's fitness to practise. Goldring J also stated that the Panel may take into account the public interest in the wider sense.

The Legal Assessor also advised the Panel of the definition of misconduct given by Lord Clyde in *Roylance v the GMC Privy Council Appeal number 49 of 1998* namely, “misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances”.

The Panel had heard the case of Dr X with that of Mr F and has considered each case separately.

The facts that the Panel has found proved are as follows:

XXXX Limited was the registered owner of XXXX Nursing Home, XXXX, XXXX ('the Home'). The Home had been registered with XXXX Health Authority (and previously with XXXX Health Authority) in accordance with the Registered Homes Act 1984 ('the Act') since [date removed].

At all relevant times Dr X was a Director of XXXX Limited and she was therefore responsible with her husband, Mr F, for ensuring that the Home was in compliance with the Act and the Nursing Homes and Mental Nursing Homes Regulations 1984 ('the Regulations').

Dr X and Mr F were the two directors of XXXX Limited. The Panel found that Dr X maintained a constant presence and hands-on involvement in the running of the Home.

During the operation of the Home Dr X appointed a series of members of staff as the “person in charge” of the Home for the purposes of the Act and the Regulations. These members of staff, also known as the matron, included Mrs A and Mrs B. At various times when Mrs A and Mrs B worked at the Home Dr X interfered in the exercise of their duties as “person in charge”. The Panel in particular noted the evidence of staff at the Home that whilst Dr X did not involve herself in clinical care, she sought to intervene with those providing clinical care by changing the decisions of those in charge and thereby undermining their authority.

The Panel heard evidence that Dr X did not permit the matron to recruit staff. She did not ensure that there was an adequate number of nursing, caring, domestic and kitchen staff and as a result staff were frequently asked to perform work outside their normal duties.

Dr X did not ensure that such staff as were appointed were suitable for their positions. The Panel accepted evidence from the matrons who worked in the Home at the time who should have been given the responsibility for recruiting staff, that this was in fact carried out by Dr X. Written references were not taken up and the matrons were not allowed to be involved in taking up references or checking nurses' PIN numbers with the Nursing and Midwifery Council. In addition, care staff were recruited with no previous experience and Dr X did not ensure that staff were adequately trained or inducted.

Dr X did not ensure that there were adequate supplies of food for residents and that the food was of an acceptable quality. She attempted to ration other supplies including the supply of incontinence pads and on one occasion Mrs A was told to instruct staff to re-use incontinence pads.

Dr X did not permit Mrs B to assess patients prior to or on admission to the Home. Concerning the importance of assessment by the matron, the Panel accepted the evidence of Miss C, a former level one nurse at the Home, that:

“The matron is appointed to her post because she is considered to be the most capable or experienced person to assess the needs of an elderly vulnerable sick patient who needs long-term care, or needs specific care with a particular medical or surgical condition. That is why she is there. She is able to assess how her staff can cope with a particular condition, whether she has got the right level or quality of skills. The skill mix was vital to get that right and it was never right. The skill mix was so important with the number of patients and conditions we had, and the matron understood that. A first level nurse would understand the complete picture of a new resident coming into a home that was already functioning at high capacity and in difficulty in many times, but that never happened. How [the doctor] assessed the patients coming in, I never knew. They just arrived.”

Dr X did not make suitable alternative arrangements for nursing and the nursing management of the Home during Mrs B's absence between [date removed] and late [date removed]. During that time XXXX should have had a level one nurse as the “person in charge” at all times but that was not the case.

The Panel heard evidence in relation to two residents who have been referred to in this hearing as Residents X and Y.

Resident X, a patient with widespread arterial disease, was resident at the Home from [date removed] to [date removed]. The Panel found that the initial nursing plan for Resident X was inadequate for his needs and that staff did not take adequate action to prevent the development of pressure sores. When pressure sores did develop they were not adequately treated. Resident X's general practitioner was not consulted about the pressure sores until [date removed] and on [date removed] Resident X was admitted to hospital. The staff at the Home did not keep Resident X's relatives adequately or accurately informed of his condition. The Panel accepted evidence from Resident X's son-in-law, Dr D, that when they asked, he and his wife had been told repeatedly about one small bed sore that was relatively superficial and not causing any concern. However, when Resident X was admitted to hospital Dr D and his wife were told by hospital staff who admitted him that there were three large, deep sores, down to the bone.

It was clear to the Panel that Resident X received a seriously inadequate level of care at the Home for which Dr X was responsible.

On [date removed] Resident Y, a 70 year old severely disabled man with paraplegia, cerebral palsy and associated mental handicap (learning disabilities) was admitted to the Home. Resident Y should not have been accepted at the Home, as it was not registered to take people with learning disabilities. The Panel accepted evidence that it was Dr X who took the decision to admit Resident Y.

The Panel heard evidence that owing to his physical condition, Resident Y required constant care for all his daily living needs. His sister normally cared for Resident Y at home but he was admitted to XXXX for a period of respite care. Owing to his physical condition he required a soft diet and it was essential that he drank plenty of fluids. Resident Y also had a urostomy fitted which his sister was able to fit so that the function of the urostomy was not obstructed. As a result, Resident Y was always clean and dry.

At the time of Resident Y's admission to the Home there was no appropriately qualified person in charge. Resident Y was not adequately assessed on admission to the Home and the care plans produced for Resident Y during his stay in the Home were inadequate for his needs.

Staff did not take adequate steps to maintain Resident Y's levels of hydration and nutrition.

The Panel accepted the compelling and clear evidence from Mr E, Resident Y's former social carer, who visited him at the Home on two occasions. Mr E told the Panel that Resident Y's sister gave him excellent care when he was at home with her and kept him in an immaculate condition. However, Mr E told the Panel that when he visited Resident Y in the Home in the second week after his admission, he found that Y was wet with urine and when he reported this to a nurse or carer no one came to attend to him. Mr E said that on the next occasion he visited Y he found him in bed, turned to the wall, a water jug and glass on a table to the side of the bed behind him. Because of Y's lack of mobility, he could not have reached the water jug or poured himself a drink so was unable to maintain his own hydration. The Panel accepted the evidence from witnesses that inadequate attention was paid to ensuring that he was fed appropriately.

Staff did not take adequate action to prevent the development of pressure sores. On [date removed] Resident Y was admitted to hospital as an emergency. At that time he had hypothermia, hypotension, septicaemia associated with a deeply extending sacral pressure sore, a purpuric rash on his chest and consolidation in his left lung. Resident Y died in hospital on [date removed].

Resident Y received a seriously inadequate level of care at the Home for which Dr X was responsible.

Regular inspections of the Home from early in its registration until [date removed] revealed continuing failures to abide by the Regulations. On [date removed] XXXX Ltd was served with a Notice alleging continuing failures to comply with the

requirement to provide minimum staffing levels. On [date removed] XXXX Ltd was served with a Notice alleging failures to comply with the arrangements for the recording, safekeeping, handling and disposal of drugs.

On [date removed] at XXXX Magistrates Court XXXX Ltd was convicted of two offences of failing to comply with the above Notices and was fined £1750 in relation to each offence.

The Panel found that as a result of her actions as set out above Dr X failed to act in the best interests of the residents at her Nursing Home.

As one of the two directors of the company registered to operate the Home, Dr X was obliged to act under the relevant Regulations. These set out the minimum standards required within a Nursing Home such as XXXX. They make clear that the responsibility for ensuring that these standards can be met lies with the “registered person”, in this case the Company acting through its directors.

Dr X must have been aware of the NHS Guidance on Standards and Inspections of Nursing Homes within XXXX (1994, revised in 1999). The purpose of this guidance was to help those involved in the ownership and running of Nursing Homes, to define the roles and responsibilities of the “registered person” and the “person in charge” and to ensure a sufficient and suitable standard in the quality of care provided. As a medically qualified director, Dr X was better able than a lay person to notice, assess and act on deficiencies relating to the delivery of care to vulnerable residents with a range of medical disorders of varying severity. Additionally, as a doctor she was in a position to understand what was needed for the health and well-being of frail, elderly people in terms of nutrition, hydration, warmth and care and yet failed to provide these basic requirements.

The Panel also heard evidence about the high turnover of staff at the Home, particularly of nurses and carers. For a number of reasons, Dr X also had difficulty in keeping managers or matrons of the Home for a sustained period of time. This placed an added responsibility on the two directors to ensure that the numbers and type of staff at the Home were applicable to the needs of the residents at the time.

The Panel also took account of the evidence relating to the inspection visits undertaken by the Local Authority and the Health Authority. It heard that Dr X was given opportunities to make improvements to the running of the Home. There were continued efforts and support from the Health Authority from 1994 through to 2000, at one period between XXXX1999 to XXXX 2000 resulting in 91 visits by members of the inspection team who made clear what the shortcomings at XXXX were and what needed to be done to rectify them. By this process Dr X was given numerous opportunities to put things right and the Panel accepted the evidence of the Head of the Inspection Unit that they only commenced prosecutions as a very last resort.

The Panel has heard that Dr X did not personally provide medical care at the Home and that this was provided by local general practitioners. However, as one of the two

directors of the company registered to run the Home for the nursing and residential care of elderly and vulnerable people, she had a responsibility to provide the residents with suitable and sufficient care, and had a duty of care for their well-being. Dr X, having worked for a period of time in geriatric medicine, should have known the standards of nursing and the importance of nursing care in the care of the elderly and the steps to take.

The Panel has found that Dr X provided a seriously inadequate level of care at the Home for which she was responsible. Further, she failed to provide adequate levels of staff, supplies, equipment, food and drink for the residents of her Nursing Home and she did not allow the matrons to assess new patients prior to admission to the Home. She also provided a seriously inadequate level of care for Residents X and Y at the Home for which she was responsible and was a director of XXXX Limited which was convicted of two offences and fined in respect of each offence.

The Panel has determined that by her acts and omissions Dr X's conduct fell short of what would be proper in the circumstances and therefore amounts to misconduct. In deciding what would be proper in the circumstances, the Panel had regard to the role of a doctor and how that relates to being a person involved in the management of healthcare. The Panel considered the guidance available to it and which was in circulation at the time of the events that occurred in this case. In particular, the Panel referred to the GMC's guidance on Professional Guidance and Discipline: Fitness to Practise (the Blue Book) which was issued in December 1993, 'Good Medical Practice' (1995 and 1998 editions) and the GMC's guidance on 'Management in Health Care: The role of doctors' issued in December 1999. The Panel noted the GMC's statement about the duties of a doctor registered with the GMC in 'Good Medical Practice' and the guidance on management in health care that:

“Patients must be able to trust doctors with their lives and well being.

To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life.”

The Panel has also noted the following statements in the guidance referred to that:

- Doctors must be trustworthy, and
- Work with colleagues in the ways that best serve patients' interests.

They have also paid attention to the guidance for doctors acting as managers which states:

“When they act as managers, doctors have a duty towards patients, the wider community, the organisation in which they work and their colleagues. The first consideration must be the interests and safety of patients”, and

“Managers should contribute to providing an environment in which all their colleagues – including colleagues from other disciplines – are able to fulfil their

professional duties so that standards of practice and care are maintained and approved”.

While the guidance on 'Management in Health Care' may not have been available to Dr X at that time, the standards set are so obvious as to have been expected by patients and easily recognisable and understood by managers and doctors alike.

The Panel also noted that the Blue Book (1993) provided guidance that doctors working as managers who manage, direct or perform clinical work for organisations offering private medical services should satisfy themselves that those organisations provide adequate clinical care and therapeutic facilities for the services offered. While the Panel recognises that XXXX Nursing Home did not provide medical services to its residents in the strict sense, it considers that the principle contained in that guidance also applies to the provision of nursing care.

The Panel considers that Dr X's misconduct is very serious, made more grave as it took place over a period of several years. It has borne in mind the need to protect the public interest, which includes the maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour. The public must be able to place trust in doctors.

Dr X's conduct has shown that she cannot justify the trust placed in her by the public.

Taking all these matters into account, the Panel has therefore determined that Dr X's fitness to practise is impaired by reason of her misconduct.”