Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 13 May 2024 – Friday, 24 May 2024
Tuesday, 28 May 2024

Virtual Hearing

Name of Registrant:	**Marcus James Dresh**
NMC PIN	87H0156S
Part(s) of the register:	Nurses part of the register Sub part 1 RN1: Adult nurse, level 1 (04 October 1990)
Relevant Location:	Greenock
Type of case:	Misconduct
Panel members:	Rachel Onikosi (Chair, lay member) Rashmika Shah (Registrant member) Hannah Harvey (Registrant member)
Legal Assessor:	Robin Hay
Hearings Coordinator:	Opeyemi Lawal (13 -24 May 2024) Stanley Udealor (28 May 2024)
Nursing and Midwifery Council:	Represented by Giedrius Kabasinskas, Case Presenter
Mr Dresh:	Not present and unrepresented
Facts proved:	Charges 1, 2, 3, 4, 5(a-c), 6, 7(a-d), 8b, 10(a-b), 11(a-f), 12, 13(a-d), 14(a-f), 15(a-c), 16(a-d) and 17(a-b)
Facts not proved:	Charges 8a, 8c, 9, 11(g-i) and 18
Fitness to practise:	Impaired

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

Previous allegation against registrant – a document seen by panel

In the hearing bundle prepared by the NMC, there was included the determination by a Nursing and Midwifery Council (NMC) panel in regard to a previous allegation against Mr Dresh. This document was included erroneously and although the panel has read the document, it is able, as a professional panel, to put it out of its mind when considering the allegations currently before it. However, Mr Kabasinskas, later in the course of the hearing, made an application under Rule 31 to adduce a section of that earlier determination in order to establish a factual matter relevant to the current charges.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Dresh was not in attendance and that the Notice of Hearing letter had been sent to Mr Dresh's registered email address by secure email on 10 April 2024.

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

The panel accepted the advice of the legal assessor.

The Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Dresh's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Dresh

The panel next considered whether it should proceed in the absence of Mr Dresh. It had regard to Rule 21 and Mr Kabasinskas' submission that the panel should continue in his absence.

Mr Kabasinskas said that there had been no recent engagement at all by Mr Dresh with the NMC in relation to these proceedings and he referred to the email dated 26 May 2022, from Mr Dresh's legal representative to the NMC which states:

> *'Mr Dresh has told us that he no longer wishes to engage with the NMC regulatory process. Accordingly, we will closing down our file here.'*

Mr Kabasinskas' submission was that there was no reason to believe that an adjournment would secure his attendance on some future occasion as Mr Dresh has voluntarily absented himself.

The panel accepted the advice of the legal assessor.

The panel was aware of its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mr Dresh. In reaching this decision, the panel has considered the submissions of Mr Kabasinskas and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Dresh;

- Mr Dresh has not recently engaged with the NMC and has not responded to any of the letters sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Witnesses are due to attend the hearing and not proceeding may inconvenience the witnesses;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Dresh. The panel will draw no adverse inference from Mr Dresh's absence in its findings of fact.

Details of charge

That you, a registered nurse whilst working at the Holy Rosary Care Home ('the Home') as clinical lead from 4 July 2019 to April 2020 and as Home Manager from 2 April to 2 October 2020

1. On application dated 10 June 2019 for the clinical lead role declared the information was correct and complete and did not disclose your employment with Alpha Care Management Services, as the Home Manager of Cambroe Care Centre between 6 May 2014 and 19 December 2014,

2. At your interview on or around 3 June 2019 did not disclose your employment with Alpha Care Management Services, as the Home Manager of Cambroe Care Centre between 6 May 2014 and 19 December 2014

3. Your conduct at charges 1 and 2 above was dishonest, in that you deliberately withheld information which you knew was prejudicial to securing employment with the home.

4. Following your awareness of Resident I, leaving the Home unaccompanied and unnoticed on 21 November and 24 November 2019 failed to implement a risk management strategy by 31 March 2020.

5. Having heard the concerns of residents and families at a meeting, that you chaired on 3 December 2019, you failed to take any or any adequate action, in that you:

    a. Failed to escalate the concerns raised.
    b. Failed to follow up in respect of the concerns raised.
    c. Failed implement an adequate system to ensure that care plans were up to date and followed.

6. On or around December 2019 as clinical lead failed to intervene when Resident F's family member was shouting and swearing at Colleague C.

7. On or around 6 April 2020 as Home Manager and the nurse on duty
    a. Failed to administer morphine to Resident A as prescribed 4 times per day
    b. Failed to change Resident C's leg ulcer bandages.
    c. Failed to order and/or chase up an order for a morphine prescription for Resident A.
    d. Failed to ensure there was an adequate system in place for the provision of breakthrough pain relief for residents

8. On or around 7 April 2020 as the nurse on duty
    a. Refused unreasonably to test Resident B's blood sugar level before instructing Colleague A to give Resident B breakfast.

b. Made an unprofessional remark in response to Colleague A ‘I throw the diabetic textbook out the window I just do what I want’ or words to that effect.
c. Unreasonably refused to examine Resident J’s foot prior to weightbearing.

9. On 8 April 2020 as the nurse on duty in relation to Resident D who had a cognitive impairment failed to conduct an examination when you had been told Resident D was complaining of chest pain.

10. As Home Manager between 2 April 2020 and 1 June 2020 failed to comply with the Health and Social Care Partnership requirements to provide:
    a. Statutory notifications of significant events and/or complaints raised against the Home.
    b. Notification of any incidents that affected the wellbeing and safety of residents.

11. Failed to ensure there were adequate infection prevention control procedures in place between 2 April 2020 and 18 June 2020 to combat the spread of covid-19 infection, in that:
    a. There were no enhanced cleaning schedules.
    b. There was no monitoring of staff compliance with infection control policies.
    c. No audits of infection control measures were undertaken.
    d. No risk assessments were completed to identify improvements.
    e. No measures were put in place to test staff competencies on infection control and prevention.
    f. There was no clear guidance issued to staff on the wearing face masks.
    g. No checks were undertaken that PCR tests had been completed by staff or visitors prior to their arrival at the home.
    h. No temperature checks were conducted in respect of staff or visitors on arrival at the home.
    i. Alcohol based hand gel was not easily and readily accessible for staff use.

12. Failed to ensure that adequate infection control measures were implemented by 10 July 2020 as per the mandate from the Care Inspectorate of Scotland on 18 June 2020

13. Between 29 June 2020 and 7 August 2020 failed to implement Colleagues A's recommendations that staff adhere to

    a. Resident H's personal preferences care plan
    b. The requirement to use a hoist to move Resident K
    c. Correct moving and handling techniques.
    d. Resident M's dietary requirements

14. As the named nurse for Resident C did not ensure they received an adequate standard of care, in that one or more of the following did not occur in a timely manner, or at all:
    a. Completion of a care plan to manage the risk of a high Waterlow score
    b. Regular reviews of the Waterlow score
    c. Completion of a care plan for the prevention and/or management of pressure damage
    d. A review of the Malnutrition universal screening tool ('MUST') scores between September 2019 and March 2020 and/or implementation of a management strategy to address the risk of malnutrition.
    e. The implementation of a social care plan.
    f. Failed to ensure the inclusion, within the care plan, of clear instructions moving and handling, specifying the equipment to be used.

15. As the named nurse for Resident G did not ensure they received an adequate standard of care, in that one or more of the following did not occur in a timely manner, or at all:

a. Completion of a care plan for the prevention and/or management of pressure damage
b. A review of the Malnutrition universal screening tool ('MUST') scores and/or implementation of a management strategy to address the risk of malnutrition.
c. An assessment of the resident's ability to feed herself.

16. Between 4 July 2019 and 7 August 2020 as Clinical Lead and/or Home Manager failed to ensure an adequate system was in place for the creation, monitoring and review of Residents' care plans in that:
    a. In relation to Resident A
        i. No Waterlow score review had been completed since October 2019
        ii. No assessment of the risk and/or prevention of pressure ulcers had been completed.

    b. In relation to Resident B
        i. No Waterlow score review had been completed since January 2020
        ii. No assessment of the risk and/or prevention of pressure ulcers had been completed.
        iii. No care plan evaluation had been completed since June 2019
        iv. No Malnutrition universal screening tool ('MUST') scores had been completed since December 2019.

    c. In relation to Resident E
        i. No Malnutrition universal screening tool ('MUST') scores had been completed since November 2019

    d. In relation to Resident F
        i. No Waterlow score review had been completed since November 2019
        ii. No assessment of the risk and/or prevention of pressure ulcers had been completed.

17. Failed to conduct yourself professionally by using inappropriate and/or foul language, in that you:
    a. Stated to Colleague C ‘oh listen to Miss F…ing uppity, don’t get f…ing uppity with me’, or words to that effect.
    b. Stated ‘I’m fucking sick of this’, when told that a colleague was unwell.

18. Failed to provide any or any adequate induction to Colleague D when they commenced employment in that you, provided login details and stated that if they had any problems they should contact the helpline.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Kabasinskas to amend the wording of charge 11(g).

The proposed amendment was to reflect the evidence provided by Ms 3, during her oral evidence, in that lateral flow tests were not available during this period only Polymerase Chain Reaction (PCR) tests. It was submitted by Mr Kabasinskas that the proposed amendment would provide clarity and more accurately reflect the evidence.

11. Failed to ensure there were adequate infection prevention control procedures in place between 2 April 2020 and 18 June 2020 to combat the spread of covid-19 infection, in that:

    …

    *g. ‘No checks were undertaken that ~~lateral flow~~ **PCR** tests had been completed by staff or visitors prior to their arrival at the home.’*

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

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

Application to adduce further evidence

Mr Kabasinskas made an application to adduce a public document into evidence under Rule 31.

Mr Kabasinskas submitted that the panel had been provided with a 34-page document that has been heavily redacted, however, the document is the determination from the previous Conduct and Competence Committee hearing which took place in 2017. Mr Kabasinskas further submitted that it establishes that Mr Dresh was employed as a Home Manager at Cambroe Care Centre, between 6 May 2014 and 19 December 2014.

Mr Kabasinskas said that the previous panel found that Mr Dresh was employed and that he had made admissions at that hearing that he was the Home Manager at Cambroe Care Centre. In terms of admissibility, he submitted that the evidence is admissible as long as it is relevant and fair. The evidence is relevant as it relates to charges one and two and speaks to the specific dates of the employment. The evidence is fair to admit because it is a public document, and it has been disclosed to Mr Dresh in the past.

Mr Kabasinkas made a subsequent application to admit the following documents; Governance and management of COVID-19 Health Protection Scotland, Information guidance for care home settings and COVID-19 information and guidance for social or Community care and residential settings.

Mr Kabasinkas submitted that the documents are relevant to the charges and will also be fair to admit the documents into evidence as they are public documents.

The panel accepted the advice of the legal assessor.

The panel determined to grant both applications to admit certain parts of the previous panel's determination and the various documents, as it concluded that they were relevant to the charges and that it would not cause any unfairness to Mr Dresh**.**

Background

The charges arose whilst Mr Dresh was employed as a registered nurse by the Holy Rosary Care Home ('the Home'). Mr Dresh had been employed at the home since 4 July 2019, initially as the Clinical Lead and then subsequently appointed as the Home Manager on 2 April 2020 until his resignation on 2 October 2020.

The concerns arose out of lack of leadership provided by Mr Dresh, in supporting staff, addressing concerns raised by staff, staffing levels, inappropriate language used by Mr Dresh and other staff and overall confidence in his ability. As well as patient care and safety concerns.

The Home received complaints from residents/relatives at a meeting on 3 December 2019, this was followed by an anonymous complaint letter in March/April 2020, audits on 20 April and September 2020, a further complaint dated 29 June 2020 and unannounced inspections by the Care Inspectorate on 18 June and 30 July 2020.

The Care Inspectorate concluded on both inspections that remedial actions were required in respects of the below:

a. Clear and auditable enhanced cleaning schedules

b. Audits of infection prevention and control measurers currently in place
c. Risk assessments to identify where improvements can be made.
d. An evaluation of the correct and consistent application, implement and effectiveness of training and information; and
e. Systems to ensure that staff competencies are regularly assessed to determine that infection prevention and control measures are being implemented in line with current best practice guidance dynamic and effective action plans that address areas for improvement and drive-up quality.
f. The provider should introduce an enhanced cleaning schedule immediately as part of their infection control management systems to mitigate against the risk of contact transmission associated with Covid-19
g. The provider should update their policy on the use of face masks to ensure that this provides clear and consistent guidance for staff.

The second inspection recorded that whilst there were some improvements these were insufficient and not robust enough to protect against Covid-19.

Mr Dresh resigned prior to the disciplinary hearing and expressed to the home in his email dated 7 October 2020 to cease his nursing career.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence together with the submissions made by Mr Kabasinskas. The panel had regard to NMC guidance on Evidence (DMA-6).

The panel has drawn no adverse inference from the non-attendance of Mr Dresh. It gave due consideration to the Registrant's Response bundle collated by the NMC.

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 only if the panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Ms 1: Voluntary Consultant Nurse at the Home
- Ms 2: Bank Care Assistant at the Home
- Ms 3: Inspector at Care Inspectorate
- Ms 4: Sister at the Home
- Mr 1: Development Advisor (Care)

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

Charge 1

> *'On application dated 10 June 2019 for the clinical lead role declared the information was correct and complete and did not disclose your employment with Alpha Care Management Services, as the Home Manager of Cambroe Care Centre between 6 May 2014 and 19 December 2014'*

This charge is found proved.

In reaching this decision, the panel took into account oral and documentary evidence, including Mr Dresh's Curriculum Vitae (CV), the application form and Ms 1's oral evidence.

In Ms 1's NMC witness statement, she stated;

‘If the Nurse had disclosed their [redacted] it is likely that the Home would have held back in offering them the position and made further enquiries.’

Mr Dresh did not disclose on his CV the Home Manager role with Alpha Care Management Services, nor did he do so on his retrospective application form dated 10 June 2019.

Further, Mr Dresh had signed his application form declaring that everything contained was correct and complete. The panel concluded that Mr Dresh had a duty to declare his Home Manager role with Alpha Care Management Services as it was relevant to his application for the Clinical Lead role.

The panel found this charge proved.

Charge 2

‘At your interview on or around 3 June 2019 did not disclose your employment with Alpha Care Management Services, as the Home Manager of Cambroe Care Centre between 6 May 2014 and 19 December 2014.’

This charge is found proved.

In reaching this decision, the panel had regard to Mr Dresh’s response to the charges, contemporaneous interview notes and Ms 1 and Ms 4’s evidence.

In Ms 1’s NMC witness statement she stated;

‘If the Nurse had disclosed their [redacted] it is likely that the Home would have held back in offering them the position and made further enquiries.’

This was further confirmed by Ms 4 who attended the interview with two other individuals. The interview notes do not contain any reference to Mr Dresh disclosing his previous employment, or that any discussion took place about it.

Mr Dresh stated that he disclosed his previous role and was offered the job at the Home.

The panel heard evidence from two witnesses whom they found to be reliable and credible and corroborated each other. The panel preferred the evidence of these witnesses to what Mr Dresh has said in his response document. The panel, therefore, found this charge proved.

Charge 3

> *'Your conduct at charges 1 and 2 above was dishonest, in that you deliberately withheld information which you knew was prejudicial to securing employment with the home.'*

This charge is found proved.

In reaching this decision, the panel took into account the NMC guidance on dishonesty 'DMA-8 - Making decisions on dishonesty'.

The panel has found that Mr Dresh did not disclose his role at Alpha Care Management services, and it did not accept his account that he disclosed the information during the course of his interview. The panel concluded that he knew that he should have done so and that the only reason he withheld this information was because he knew that it might be prejudicial to his employment application. It therefore concluded that he acted dishonestly.

The panel found this charge proved.

Charge 4

> *'Following your awareness of Resident I, leaving the Home unaccompanied and unnoticed on 21 November and 24 November 2019 failed to implement a risk management strategy by 31 March 2020.'*

This charge is found proved.

In reaching this decision, the panel took into account oral and documentary evidence, including an email dated 1 May 2020, the Care Inspectorate Report dated August 2020 and Ms 1's evidence.

In Ms 1's NMC witness statement she stated;

> *'The resident was found in the grounds and their family subsequently removed the resident from the Home and complaints to the Car Inspectorate. This was ongoing in August when I arrived at the Home and so I had to complete the end of that complaint, which the Nurse should have done but did not.'*

Although there was no reference to the risk assessment management strategy in Ms 1's statement, in an email dated 1 May 2020 between Mr Dresh and the Care Inspectorate, she had written on it;

> *'The risk assessment was not completed due to the non-provision of any information.*'

The Care Inspectorate report dated August 2020 stated that the risk assessment was not completed within the timeframe, but that Ms 1 had completed it by the time of the report. In her evidence, Ms 1's confirmed that she had to complete the risk assessment because Mr Dresh had failed to do so.

The panel preferred the evidence of Ms 1 to what Mr Dresh said in his response to this charge.

The panel found this charge proved.

Charge 5

> *'Having heard the concerns of residents and families at a meeting, that you chaired on 3 December 2019, you failed to take any or any adequate action, in that you:*
>
> *a. Failed to escalate the concerns raised.*
> *b. Failed to follow up in respect of the concerns raised.*
> *c. Failed implement an adequate system to ensure that care plans were up to date and followed.'*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account all the evidence relevant to the charge, including the meeting notes 3 December 2019, email dated 29 June 2020, the Clinical Lead job description, Ms 1's evidence and Mr Dresh's response.

Ms 1's evidence was;

> *'These complaints were the sole responsibility of the Nurse as they were chairing the meeting. The Nurse had a duty and responsibility to ensure that they acted on these complaints by addressing the concerns raised by taking steps to make improvements in the areas complained of…There should have been an action plan formulated to address what would come out of that meeting but there is no evidence that a plan was put in place and I do not think that one was put in place.'*

The meeting notes dated 3 December 2019 show that Mr Dresh led the meeting.

In his response, Mr Dresh said that he did escalate the concerns raised but there was no evidence to show that he escalated or followed up the concerns and/or implemented an adequate system to ensure care plans were up to date and followed.

The panel found that based on the clinical lead job description and the evidence of Ms 4, Mr Dresh had the responsibility to escalate the matters raised.

The panel therefore determined that this charge is found proved in its entirety.

Charge 6

> '*On or around December 2019 as clinical lead failed to intervene when Resident F's family member was shouting and swearing at Colleague C.'*

This charge is found proved.

In reaching this decision, the panel took into account oral and documentary evidence, including statements from Colleagues that were exhibited by Ms 1.

Although the local statements from the two colleagues are hearsay, they describe the incident, and the statements were taken in the course of Ms 1's local investigation.

Whilst Mr Dresh acknowledged that an incident occurred, he gave a different account to the effect that he led Colleague C away and had a word with the relative. The panel preferred what was said by Colleague C and corroborated by Colleague G to Mr Dresh's account.

This charge is found proved.

Charge 7

'*On or around 6 April 2020 as Home Manager and the nurse on duty*

a. Failed to administer morphine to Resident A as prescribed 4 times per day

b. Failed to change Resident C's leg ulcer bandages.

c. Failed to order and/or chase up an order for a morphine prescription for Resident A.

d. Failed to ensure there was an adequate system in place for the provision of breakthrough pain relief for residents.'

This charge is found proved in its entirety.

In reaching this decision, the panel took into account oral and documentary evidence, including Ms 1's evidence, Ms 3's NMC witness statement, an email from Ms 2 to the Care Inspectorate dated 8 April 2020 and the interview notes dated 24 August 2020.

In Ms 3's NMC witness statement she stated;

> *'The Resident was on end of life care and had not been given morphine when the Nurse was on shift. This was alleged to have happened on 6 April 2020. The nurse who had administered a dose of morphine had noticed a significant gap between the doses, despite the resident crying out in pain. This nurse had been surprised that no medication had been administered to this resident.'*

In her email, Ms 2 listed her concerns in particular those which are set out in charges 7a – b. In her evidence, Ms 1 referred to concerns which were raised in the course of her investigation. These related to the matters set out in charges 7c and d.

This charge is found proved in its entirety.

Charge 8a)

‘On or around 7 April 2020 as the nurse on duty

a. Refused unreasonably to test Resident B’s blood sugar level before instructing Colleague A to give Resident B breakfast.’

This charge is found not proved.

In reaching this decision, the panel took into account oral and documentary evidence, including Ms 1 and Ms 2’s evidence and Mr Dresh’s response.

In her evidence, Ms 1 said that the decision in this regard is a matter for a nurse’s clinical judgement depending on the circumstances of a resident.

Within Mr Dresh’s response he said that he did take the blood sugar levels at the most appropriate time, emphasising his in-depth knowledge about diabetes.

The panel determined that Mr Dresh exercised his professional judgement and therefore did not unreasonably refuse.

This charge is found not proved.

Charge 8b)

‘On or around 7 April 2020 as the nurse on duty

b. Made an unprofessional remark in response to Colleague A ‘I throw the diabetic textbook out the window I just do what I want’ or words to that effect.’

This charge is found proved.

In reaching this decision, the panel took into account oral and documentary evidence, including Ms 2's NMC witness statement and email to the Care Inspectorate dated 8 April 2020.

In Ms 2's NMC witness statement she stated;

> *'There was another incident on 7 April 2020 where the Nurse made a comment about a diabetic resident. The resident had type one diabetes and had their sugars taken that morning. I had asked about whether the resident was given their breakfast before their insulin or the other way around. The Nurse responded and this was questioned by another member of staff who said 'l thought we gave the breakfast first'. The Nurse responded by saying 'l throw the diabetic textbook out the window l just do what I want'.1 was taken aback by that as I thought it was not really up to the Nurse how to deal with a diabetic resident.'*

Mr Dresh agreed that he had made a comment based on the circumstances at the time.

The panel determined that Mr Dresh, as Home Manager and a senior nurse, had a responsibility to behave in a professional manner when addressing colleagues. In making this remark the panel found he did not do so.

This charge is found proved.

Charge 8c)

> '*On or around 7 April 2020 as the nurse on duty*
>
> *c. Unreasonably refused to examine Resident J's foot prior to weightbearing.'*

This charge is found not proved.

In reaching this decision, the panel took into account oral and documentary evidence, including an email from Ms 2 to the Care Inspectorate dated 8 April 2020.

Ms 2 in her evidence said that she could not say whether Resident J's foot was examined only that she had spoken to the Resident about it.

In the light of the evidence, the panel could not be satisfied that Resident J's foot was not examined by Mr Dresh.

It therefore finds this charge not proved.

Charge 9

> *'On 8 April 2020 as the nurse on duty in relation to Resident D who had a cognitive impairment failed to conduct an examination when you had been told Resident D was complaining of chest pain.'*

This charge is found not proved.

In reaching this decision, the panel took into account oral and documentary evidence, including an email from Ms 2 to the Care Inspectorate dated 8 April 2020.

Mr Dresh does not refer to this charge in his response bundle.

The panel determined that there is insufficient evidence to support this charge, as there is nothing more than a complaint that was made.

The panel determined that the NMC have not discharged the burden of proof.

This charge is found not proved.

Charge 10)

'As Home Manager between 2 April 2020 and 1 June 2020 failed to comply with the Health and Social Care Partnership requirements to provide:

a. Statutory notifications of significant events and/or complaints raised against the Home.

b. Notification of any incidents that affected the wellbeing and safety of residents.'

This charge is found proved in its entirety.

In reaching this decision, the panel took into account oral and documentary evidence, including Ms 1's NMC witness statement and minutes of the HSCP meeting, dated 11 August 2020.

In Ms 1's NMC witness statement she stated;

'There was also the issue that governance raised by HSCP that very few to no notifications had been made in a long period of time and I thought this was very strange. I could not go back and check every care plan on what had happened and so could not verify this. I do know however that there was a dismissal at the Home that the HSCP were unaware of but should have been. I would have thought that as the Home manager, the Nurse would have known about reporting this.'

Minutes of HSCP meeting, dated 11 August 2020, stated;

'The care home had, at the time, failed to notify the HSCP of these complaints via the significant event process. Discussion took place around the lack of Significant Notifications sent to the HSCP by the Care Home – noting there had only been 7 received since the start of the year and these were notifications of deaths only. Care Homes reminded of Terms and Conditions of contract and of their obligation

to notify the HSCP of any incidents which effect the wellbeing or safety of residents.'

Mr Dresh stated that he was only aware that deaths should be notified.

The panel determined that there had been evidence that notifications had not been made, and that Mr Dresh had a responsibility as the Home Manager to comply fully with the HSCP requirement.

This charge is found proved.

Charge 11a-f)

'*Failed to ensure there were adequate infection prevention control procedures in place between 2 April 2020 and 18 June 2020 to combat the spread of covid-19 infection, in that:*

a. There were no enhanced cleaning schedules.
b. There was no monitoring of staff compliance with infection control policies.
c. No audits of infection control measures were undertaken.
d. No risk assessments were completed to identify improvements.
e. No measures were put in place to test staff competencies on infection control and prevention.
f. There was no clear guidance issued to staff on the wearing face masks.'

This charge is found proved in relation to 11a-f.

In reaching this decision, the panel took into account oral and documentary evidence, including the Care Inspectorate report and evidence from Ms 1 and Ms 3.

In her evidence Ms 3 said that an anonymous complaint was received by the Care Inspectorate and consequently they conducted an unannounced inspection at the Home where the issues set out in the charges were identified.

The panel was satisfied from Ms 3's evidence that Mr Dresh failed to implement the adequate infection control procedures at the height of COVID-19, when these precautions should have been at the forefront of his mind as a Home Manager.

This charge is found proved in relation to charge 11a-f.

Charge 11g and h)

> *'Failed to ensure there were adequate infection prevention control procedures in place between 2 April 2020 and 18 June 2020 to combat the spread of covid-19 infection, in that:*
>
> *g. No checks were undertaken that PCR tests had been completed by staff or visitors prior to their arrival at the home.*
>
> *h. No temperature checks were conducted in respect of staff or visitors on arrival at the home.'*

This charge is found not proved in relation to 11g-h.

In reaching this decision, the panel took into account oral and documentary evidence, including that of Ms 3.

In her evidence, Ms 3 said that PCR tests were available during the week of the inspection.

The panel has not been provided with any government policy or guidance regarding the use of PCR tests during the time. Although Ms 3 in her evidence said that PCR testing was available at the time of the first inspection, there was no evidence before the panel to

support Ms 3's view that testing on staff and visitors was a routine requirement at that time.

In Ms 3's NMC witness statement she stated;

> *'On arrival, we did not have our temperature checked and we did query this.'*

The panel determined that even though Ms 3's temperature was not checked when she arrived, it does not necessarily mean that checks were not routinely undertaken within the Home or on visitors.

In the light of the above the panel could not be satisfied that the NMC have discharged the burden of proof.

This charge is found not proved in relation to 11g and 11h.

Charge 11i)

> *'Failed to ensure there were adequate infection prevention control procedures in place between 2 April 2020 and 18 June 2020 to combat the spread of covid-19 infection, in that:*
>
> *i. Alcohol based hand gel was not easily and readily accessible for staff use.'*

This charge is found not proved.

In reaching this decision, the panel took into account oral and documentary evidence, including Ms 3's and Ms 4's evidence.

During Ms 4's oral evidence, she stated that she remembered seeing the bottles of alcohol-based hand gel which were in baskets around the Home and easily accessible.

Further, the Home was very good at making sure that nurses and care staff had hand gel and that it was carried by them.

Based on Ms 4's evidence and her daily responsibilities at the Home, the panel concluded that she would be aware of the availability of hand-gel.

In the light of the above, the panel found this charge not proved.

Charge 12

> *'Failed to ensure that adequate infection control measures were implemented by 10 July 2020 as per the mandate from the Care Inspectorate of Scotland on 18 June 2020.'*

This charge is found proved.

In reaching this decision, the panel took into account oral and documentary evidence, including the Care Inspectorate Reports and Mr Dresh's response.

The Care Inspectorate Report dated 18 June 2020 detailed areas for improvement and what needed to be correct and complied with.

The Care Inspectorate Report dated 31 August 2020 indicated that some requirements had been completed by 10 July 2020, but identified the areas that had not been addressed by Mr Dresh.

In response to this, Mr Dresh said that he had tried to address the concerns raised and to develop an audit assurance system, but the lack of support meant it had not been fully evaluated.

In the light of the above, the panel was satisfied that Mr Dresh failed to ensure that adequate infection control measures were implemented by 10 July 2020.

This charge found proved.

Charge 13

'Between 29 June 2020 and 7 August 2020 failed to implement Colleagues A's recommendations that staff adhere to

a. Resident H's personal preferences care plan

b. The requirement to use a hoist to move Resident K

c. Correct moving and handling techniques.

d. Resident M's dietary requirements'

This charge is found proved in its entirety.

In reaching this decision, the panel took into account oral and documentary evidence, including Ms 2's email to the Nurse dated 29 June 2020, Ms 1 and Ms 2's evidence.

In their evidence, Ms 1 and Ms 2 said that Mr Dresh did not respond appropriately to the concerns raised. Ms 2 said although Mr Dresh responded to her email listing her concerns, he took no apparent actions to address them.

In response to this charge, Mr Dresh stated that he did respond to the concerns and clarified it with Ms 2. The panel preferred the evidence of Ms 1 and Ms 2, who were questioned on their evidence and were consistent with their initial account.

In the light of the above, the panel found this charge proved.

Charge 14

'As the named nurse for Resident C did not ensure they received an adequate standard of care, in that one or more of the following did not occur in a timely manner, or at all:

a. Completion of a care plan to manage the risk of a high Waterlow score

b. Regular reviews of the Waterlow score

c. Completion of a care plan for the prevention and/or management of pressure damage

d. A review of the Malnutrition universal screening tool ('MUST') scores between September 2019 and March 2020 and/or implementation of a management strategy to address the risk of malnutrition.

e. The implementation of a social care plan.

f. Failed to ensure the inclusion, within the care plan, of clear instructions moving and handling, specifying the equipment to be used.'

This charge is found proved in its entirety.

In reaching this decision, the panel took into account oral and documentary evidence, including Resident C's care plans, Mr 1's oral evidence and Ms 1's NMC witness statement.

In Ms 1's NMC witness statement she stated;

'Care plans are implemented on the basis of an assessments of the needs of the resident. Care plans should be evaluated monthly as to whether they are working and if they are not achieving what they are supposed to then they need to be re-thought.'

During Mr 1's oral evidence, he stated that he reviewed all documents digitally and then had a look at whether any outstanding documents were in hard copy.

The panel determined that after examining Resident C's care plans and documentation, the following factors within the charge were not contained in the case file. The panel are also aware that Mr 1 had conducted his assessment digitally and he also went into the Home to find the missing documents but could not find them. It was Mr Dresh's responsibility to ensure that Resident C received adequate care which also includes making sure his documentation is complete.

This charge is found proved.

Charge 15

> *'As the named nurse for Resident G did not ensure they received an adequate standard of care, in that one or more of the following did not occur in a timely manner, or at all:*
>
> *a. Completion of a care plan for the prevention and/or management of pressure damage*
>
> *b. A review of the Malnutrition universal screening tool ('MUST') scores and/or implementation of a management strategy to address the risk of malnutrition.*
>
> *c. An assessment of the resident's ability to feed herself.'*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account oral and documentary evidence, including Resident G's care plans and Mr 1's oral evidence.

During Mr 1's oral evidence, he stated that he reviewed all documents digitally and then had a look at whether any outstanding documents were in hard copy.

The panel determined that after examining Resident G's care plans and documentation, the following factors within the charge were not contained in the case file. The panel are

also aware that Mr 1 had conducted his assessment digitally and he also went into the Home to find the missing documents but could not find them. It was Mr Dresh's responsibility to ensure that Resident G received adequate care which also includes making sure his documentation is complete.

This charge is found proved in its entirety.

Charge 16)

'Between 4 July 2019 and 7 August 2020 as Clinical Lead and/or Home Manager failed to ensure an adequate system was in place for the creation, monitoring and review of Residents' care plans in that:

a. *In relation to Resident A*
    i. *No Waterlow score review had been completed since October 2019*
    ii. *No assessment of the risk and/or prevention of pressure ulcers had been completed.*

b. *In relation to Resident B*
    i. *No Waterlow score review had been completed since January 2020*
    ii. *No assessment of the risk and/or prevention of pressure ulcers had been completed.*
    iii. *No care plan evaluation had been completed since June 2019*
    iv. *No Malnutrition universal screening tool ('MUST') scores had been completed since December 2019.*

c. *In relation to Resident E*
    i. *No Malnutrition universal screening tool ('MUST') scores had been completed since November 2019*

d. *In relation to Resident F*
    i. *No Waterlow score review had been completed since November 2019*

ii. No assessment of the risk and/or prevention of pressure ulcers had been completed.'

This charge is found proved in its entirety.

In reaching this decision, the panel took into account oral and documentary evidence, including all the resident's care plans and Mr 1's evidence.

The panel had sight of the '*MUST*' care plans, the assessment and guidance policy and the audits.

The panel reviewed the care plans for all the residents and determined that there are documents missing or the reviews did not continue after a certain date, also Mr Dresh did not ensure an adequate system was in place for monitoring and reviewing the care plans in full.

The panel found this charge proved in its entirety.

Charge 17

'Failed to conduct yourself professionally by using inappropriate and/or foul language, in that you:

a. Stated to Colleague C 'oh listen to Miss F…ing uppity, don't get f…ing uppity with me', or words to that effect.

b. *Stated 'I'm fucking sick of this', when told that a colleague was unwell."*

This charge is found proved in its entirety.

In reaching this decision, the panel took into account oral and documentary evidence, including Colleague D's interview notes dated 11 September 2020, Colleague C's local investigation statement and Mr Dresh's response.

In Colleague D's interview notes, it stated:

> *'She details an incident where she had to report to Marcus that a member of staff had phoned in sick and he shouted at her, "I'm F-----g sick of this".'*

In Colleague C's local investigation statement, it stated:

> *'I said "I don't eat in here, I just need a drink "I had not stopped and was just taking a drink. He then said, "Oh listen to Miss F…ing uppity, don't get f….ing uppity with me"*
>
> *I said "don't you speak to me like that."*
>
> *My colleague witnessed this and after the report I left. I went to speak to him again but he did not seem to think there was anything wrong with this. I felt this was totally unprofessional and demeaning.'*

Mr Dresh admitted that he uses this type of language and apologised that he spoke to his colleague in this manner.

On the balance of probabilities, it is more likely than not Mr Dresh did speak to his colleague in this manner.

This charge is found proved.

Charge 18

> *'Failed to provide any or any adequate induction to Colleague D when they commenced employment in that you, provided login details and stated that if they had any problems they should contact the helpline.'*

This charge is found not proved.

In reaching this decision, the panel took into account oral and documentary evidence.

There is quite limited evidence in relation to this charge, and also Colleague D is a bank member of staff. The panel would have found it beneficial to have sight of an induction policy, which would outline individual responsibilities and what is expected of a bank staff.

In the light of the above, the panel cannot find this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then considered whether the facts found proved amount to misconduct and, if so, whether Mr Dresh's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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, Mr Dresh's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Kabasinskas referred the panel 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.'*

Mr Kabasinskas' submission was 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 (2015)' (the Code) in making its decision.

Mr Kabasinskas identified the specific, relevant standards where Mr Dresh's actions amounted to misconduct, in particular codes; 1.1, 1.2, 1.4, 2.2, 3.1, 7.4, 8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 9.3, 9.4, 10.2, 14.1, 16.4, 19.4, 20.1, 20.3, 23.4, 25.1 and 25.2.

Mr Kabasinskas reviewed each of the charges.

Charges 1, 2 and 3

Mr Kabasinskas said that honesty is a fundamental cornerstone of a profession, and to comply with a professional duty, nurses must be open and truthful in all of their dealings with patients and with their employer.

Mr Kabasinskas submitted that Mr Dresh's conduct at charges 1 to 3 does not uphold the standard and instead fell short of what is expected of a registered nurse, amounting to misconduct.

Charge 4

Mr Kabasinskas submitted that upon Mr Dresh becoming aware of the resident leaving the home unaccompanied, and his failure to implement a risk management strategy to prevent such instances amounts to misconduct. Mr Kabasinskas further submitted that this requirement was highlighted by the Care Commissioner and the time scale was given to

implement the system, as without this system in place, residents could leave home unnoticed, and this would put residents at the risk of harm.

Charge 5

Mr Kabasinskas submitted that Mr Dresh's actions amounted to misconduct because they relate to a failure to escalate and follow up concerns raised. He was in a position of responsibility, and had a duty to act upon those complaints.

Charge 6

Mr Kabasinskas submitted that Mr Dresh's actions amounted to misconduct because they relate to a failure to protect a member of staff. Mr Dresh was in a senior position and he had a duty to act accordingly.

Mr Kabasinskas submitted that if the panel does not find this charge amounts to misconduct, when considered together with charge 17, it would do so.

Charge 7

Mr Kabasinskas submitted that Mr Dresh's actions amounted to misconduct because they relate to his failings in medication administration and patient care, and these are fundamental parts of the nursing profession.

Charge 8b and 17

In relation to charge 8b, regarding unprofessional language, Mr Kabasinskas submitted taken in isolation it may not amount to misconduct.

Mr Kabasinskas submitted that if the panel does not find charge 8b amounts to misconduct, when considered together with charge 17, it would do so.

Mr Kabasinskas submitted that the remaining charges found proved amount to misconduct.

Submissions on impairment

In regard to impairment, Mr Kabasinskas referred to the need to have regard to protecting the public and the wider public interest. This included declaring and maintaining proper standards of behaviour and public confidence in the profession and in the NMC as a regulatory body. He referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kabasinskas submitted that Mr Dresh has demonstrated failures across areas of nursing and non-nursing practise, which raises clinical and attitudinal concerns.

Mr Kabasinskas' submission was that Mr Dresh's widespread failures in clinical and managerial practise, together with his dishonesty, raise both clinical and attitudinal concerns. Also, his responses further indicate that his conduct raises attitudinal concerns, especially in regard to the dishonesty element. Mr Dresh has not provided any information as to his attempts to strengthen his clinical practice.

Mr Kabasinskas referred to Mr Dresh's reflective piece, he submitted that this demonstrates limited insight into his actions and this together with his generic responses suggests that there remains a risk of repetition. Most importantly, Mr Dresh has not provided a response to or a reflection about the element of dishonesty.

Mr Kabasinskas submitted that a finding of impairment on public interest grounds is also necessary to maintain public confidence and professional standards as there are fundamental concerns about Mr Dresh's trustworthiness.

The panel accepted the advice of the legal assessor.

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 determined that Mr Dresh's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Dresh's actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *2.1 work in partnership with people to make sure you deliver care effectively*
> *2.2 recognise and respect the contribution that people can make to their own health and wellbeing*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> ***6 Always practise in line with the best available evidence***
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> ***8 Work co-operatively***
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *8.2 maintain effective communication with colleagues*

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.4 work with colleagues to evaluate the quality of your work and that of the team
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your 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
9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place
14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

16 Act without delay if you believe that there is a risk to patient safety or public protection
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

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

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

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

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

20 Uphold the reputation of your profession at all times

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

23 Cooperate with all investigations and audits

23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment.

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

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

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.

The panel found that Mr Dresh's dishonesty amounts to serious misconduct.

The panel determined that Mr Dresh's actions amounted to misconduct because the failures were wide-ranging and put residents at risk of harm. The panel found that Mr Dresh did not fulfil the responsibilities of his role as a Home Manager and Clinical Lead, whether that be supporting colleagues, complying with guidelines or escalating concerns.

The panel found that Mr Dresh's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel then considered whether as a result of the misconduct found proved, Mr Dresh's fitness to practise is currently impaired.

In reaching its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

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

The panel found that residents were put at risk of harm as a result of Mr Dresh's failings. By his misconduct, he was in breach of the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was therefore satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel found that Mr Dresh has demonstrated a limited understanding of how his actions put residents at a risk of harm, why what he did was wrong and how this impacted negatively on the reputation of the nursing profession. Mr Dresh's partial responses were generic and did not show how he would handle the situation differently in the future.

The panel was satisfied that the clinical and managerial failings could be remedied but there is no information from Mr Dresh about any steps he has taken to do so. Furthermore, he has not provided any testimonials from colleagues. In regard to attitudinal matters, particularly involving dishonesty, the panel concluded that these are difficult to remedy.

The panel therefore concluded that in the absence of an appropriate level of insight and remedial steps, there is a high risk of repetition. The panel decided that a finding of current 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 further concluded that members of the public would find Mr Dresh's failings deplorable and that public confidence in the profession would be undermined if a finding of current impairment were not made. The panel therefore finds Mr Dresh's fitness to practise currently impaired on public interest grounds.

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

Sanction

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

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

Submissions on sanction

Mr Kabasinskas informed the panel that the NMC would seek the imposition of a strike-off order now that the panel has found Mr Dresh's fitness to practise currently impaired.

Mr Kabasinskas submitted that taking no further action would not be an appropriate sanction because Mr Dresh has shown limited insight, lack of remorse and has failed to provide evidence of having strengthened his practice. As a result, this poses a continuing risk of harm to patients.

In relation to imposing a caution order, Mr Kabasinskas submits that this would not be appropriate because the risk of harm still remains, and such an order would not adequately reflect the seriousness of concerns.

In relation to imposing a conditions of practice order, Mr Kabasinskas submits that whilst it might be an appropriate sanction to address the clinical failures and protect the public, it does not appear that Mr Dresh has learned from his mistakes given his past regulatory findings. Furthermore, Mr Dresh's attitudinal issues and his unwillingness to learn or seek support means that it is unlikely that he would comply with conditions, thus, continuing to put patients at risk of harm. Further, a conditions of practice order would not be appropriate to address the dishonesty concerns.

In regard to a suspension order, Mr Kabasinskas submitted that the charges found proved relate to Mr Dresh's professionalism, his attitude towards patients and colleagues, and general concerns about his leadership and knowledge. Mr Dresh's actions particularly during COVID-19 put patients and colleagues at significant risk of harm with the lack of action in dealing with matters raised by the care inspectorate and other regulators. The lack of recognition of seriousness of the concerns or proper acknowledgement of his role is a concern both as a clinical lead and a home manager. Mr Kabasinskas therefore submits that a suspension order would not be appropriate given the deep-seated attitudinal concerns, repetitive poor leadership and previous fitness to practise matters.

Mr Kabasinskas submitted that a striking-off order is the only sanction sufficient to protect patients, members of a public and to maintain professional standards.

Mr Kabasinskas outlined mitigating and aggravating features.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

In reaching its decision, 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:

- Previous regulatory concerns.
- Pattern of behaviour from April 2019 to July 2020.
- Lack of insight into his failings.
- Failures that put patients at risk of harm; and
- Attitudinal concerns.

The panel also took into account the following mitigating features:

- Some of the failures occurred during the height of COVID-19 pandemic; and
- Poor management structure and difficult staffing levels at the Home.

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

The panel 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 Mr Dresh's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel decided that Mr Dresh's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel concluded 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 Mr Dresh's registration would be a sufficient and appropriate response. The panel found that whilst it might be an appropriate sanction to address the clinical failures and protect the public, it does not appear that Mr Dresh has learned from his mistakes given his past regulatory findings. Furthermore, the panel determined that Mr Dresh's attitudinal issues and his unwillingness to learn or seek support suggests that it is unlikely that he would comply with conditions. The panel concluded that the placing of conditions on Mr Dresh's registration would not adequately address the misconduct and would not protect the public.

The panel next considered a suspension order. The SG states that a suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee was satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…….;*
- *……..'*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel determined that the serious breach of the fundamental tenets of the profession evidenced by Mr Dresh's actions is fundamentally incompatible with him remaining on the register.

The panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In regard to a striking-off order, the panel had in mind the following paragraphs of the SG:

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

Mr Dresh's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel concluded that the findings in this particular case demonstrate that Mr Dresh's actions were so serious that to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulator.

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

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

This will be confirmed to Mr Dresh in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Kabasinskas. He referred the panel to Rule 24 (14) which makes provisions for the consideration of an interim order by the panel pending the outcome of any appeal following its decision on sanction.

Mr Kabasinskas further referred the panel to the NMC Guidance on Interim Orders. He submitted that given the findings of the panel on the facts found proved, the panel would not need to make any further decision on the evidence of the concerns. He further reminded the panel that it had determined that there is a risk of repetition on both clinical and leadership concerns in this case and based on the seriousness of the concerns, therefore, an interim order is necessary for the protection of the public.

Mr Kabasinskas submitted that a member of the public, aware of the panel's findings on the substantive striking-off order, would be very concerned if Mr Dresh were allowed to practise unrestricted during any potential appeal period. Therefore, an interim order is otherwise in the public interest.

Mr Kabasinskas therefore concluded that, given that the panel has determined that a striking-off order is appropriate and proportionate, an interim suspension order for a period of 18 months is necessary in order to protect the public and is also otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective.

The panel accepted the advice of the legal assessor.

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 in order to protect the public and otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

If there is no appeal, the interim suspension order will be replaced by the substantive striking-off order 28 days after Mr Dresh is sent the decision of this hearing in writing.

That concludes this determination.