Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday 6 December 2021

Virtual Meeting

Name of registrant:	Mrs Valerie Ellen O'Brien
NMC PIN:	77A4263E
Part(s) of the register:	RN1: Adult Nurse, Level 1 (10 April 1992) RN2: Adult Nurse, Level 2 (8 December 1980)
Area of registered address:	Hertfordshire
Type of case:	Misconduct
Panel members:	Dale Simon (Chair, Lay member) Lorraine Shaw (Registrant member) Susan Ellerby (Lay member)
Legal Assessor:	John Donnelly
Panel Secretary:	Megan Winter
Consensual Panel Determination:	**Accepted**
Facts admitted in the CPD:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel considered whether notice of this meeting has been served in accordance with Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ('the Rules').

The panel accepted the advice of the legal assessor. The panel noted that, under the amendments made to the Rules during the Covid-19 emergency period, a notice of hearing or meeting can be sent to a registrant's registered address by recorded delivery and first class post or to a suitable email address on the register.

The panel noted that Mrs O'Brien's representative at the Royal College of Nursing (RCN), on her behalf, confirmed in an email to the NMC on 26 November 2021 that Mrs O'Brien was content to waive the full statutory notice period so that her case could be heard sooner.

Notice of this substantive meeting was subsequently sent to the Mrs O'Brien by email on 1 December 2021.

The notice informed Mrs O'Brien that a panel of the Fitness to Practise Committee would hold a meeting to consider her case on 6 December 2021. The notice included the charges which the panel would consider at the meeting, as well as informing the Mrs O'Brien that the panel would decide whether her fitness to practise is currently impaired as a result of those charges and, if so, whether a sanction is required.

In these circumstances, the panel was satisfied that there had been effective service. It noted that Mrs O'Brien has engaged with the NMC and agreed a CPD for this panel's consideration, which represents an agreed position between the NMC and Mrs O'Brien. The panel was therefore also satisfied that it was both appropriate and fair to proceed with this matter at a meeting.

Details of charge

That you a registered nurse, whilst acting as manager of the Lakeside Care Centre;

1. In relation to service user A's prescription for Lorazepam did not ensure that guidance was provided to staff as to how service user A's anxiety presented.

2. In relation to service user B's prescription for metoclopramide did not ensure that instructions were provided as to why this would be administered.

3. In relation to service user B's prescription for eye drops did not ensure that guidance was provided as to whether both eyes required eye drops.

4. In relation to service user C's prescription for pain relief medication did not ensure that guidance as to whether the pain relief prescribed was to be given together or at separate times.

5. In relation to service user C's prescription cream did not ensure;

    a. that guidance was provided as to where the cream needed to be applied;
    b. that a body map was provided so that it could be marked as to where the cream was to be applied.

6. In relation to service user D's transdermal patch did not ensure that records were maintained as to where the transdermal patch was applied.

7. In relation to service user E 's prescription cream did not ensure;

    a. that guidance was provided as to where the cream needed to be applied;
    b. that a body map was provided so that it could be marked as to where the cream was to be applied.

8. In relation to service user E did not ensure that the moving and handling risk assessment was always completed in that it did not include;

    a. The management plan for managing the risk;
    b. The equipment used.

9. In relation to service user E did not ensure that a risk assessment was in place as to how staff would recognise one or more of the following conditions:

    a. Hyperglycaemia;

b. Hypoglycaemia;
c. Epilepsy.

10. In relation to Service user E's care plan on promoting skin integrity did not

a. ensure that the record was updated since April 2018;
b. ensure that details were provided as to what constituted regular contact.

11. Did not ensure that service user E's care plan included the following information:

a. Prescription for apixaban.

b. Any potential risks that staff needed to be aware of in relation to the prescription for apixaban.

12. In relation to service user F's prescription cream did not ensure;

a. That guidance was provided as to where the cream was to be applied;
b. That a body map was provided so that it could be marked as to where the cream was to be applied.

13. In relation to service user G's prescription for eye drops did not ensure that guidance was provided as to whether both eyes required eye drops.

14. Did not ensure that guidance or a risk assessment was in place to support the practice of leaving doors open.

15. Allowed boxes of thickeners to be left in service user H's bedroom despite the containers displaying a notice stating 'do not leave at patients bedside'.

16. In relation to service user H risk assessment did not ensure that service user H was supervised during meal times.

17. In relation to service user H's challenging behaviour did not ensure that that there was a risk assessment in place to guide staff on how to

a. Manage the risks to themselves;
b. Manage the risks to service user H.

18. In relation to service user H's history of falls did not ensure that his falls risk assessment detailed;

a. That a sensor mat had been considered;

b. The reason why a sensor mat was deemed inappropriate.

19. Did not ensure that service user H;s care plan made reference to one or more of the following medical conditions:

    a. Epilepsy;
    b. Parkinsons disease.

20. In relation to Service users H's medical conditions referred to at charges 19 a, and or b did not ensure that the care plan reflected the following:

    a. The level of support required
    b. Whether any intervention was required
    c. Whether any emergency action is required following a seizure.

21. In relation to an incident regarding manual evacuation of service user H's bowels did not investigate the matter properly in that you did not interview the key witness.

22. Did not ensure that service user H's mental capacity assessment was complete.

23. Did not ensure that service user H's MAR chart recorded the following information:

    a. Whether service user H was able to consent to medication being crushed and given in yoghurt
    b. Whether medication was to be given covertly.
    c. If medication was to be given covertly did not record best interest decision to support the practice.

24. In relation to service user H's challenging behaviour did not;

    a. Ensure that reference to his challenging behaviour was recorded in his care plan.
    b. Ensure that a behavioural care plan was in place.

25. In relation to service user I who was perceived to be at risk of choking did not;

    a. Ensure that their care plan referred to the risk of choking;
    b. Ensure that their care plan referred to the level of supervision required.

26. In relation to service user J's PEG did not ensure that a risk assessment was in place.

27. In relation to service user L who had sustained a number of falls did not ensure that any action to mitigate the risk of falling had been recorded

28. In relation to service user M's fall did not ;

    a. Ensure that the injury was reported;
    b. Ensure that the matter was investigated.

29. In relation to service user O did not ensure that their care plans referred to one or more of their following health conditions:

    a. Epilepsy ;
    b. Parkinsons disease.

30. Did not ensure that the home had an environmental risk assessment.

31. In relation to staff training

    a. Did not keep records to demonstrate which members of staff had completed their induction;
    b. Did not ensure that a system was in place which outlined what training was required for each role;
    c. Did not include training certificates for all the training recorded on the training matrix ;
    d. Did not ensure that SM7's had received moving and handling training;
    e. Did not ensure that SM8 who was the designated moving and handling trainer had received the appropriate training to deliver training;
    f. Did not ensure that SM4 was competent to carry out a digital evacuation of service user H's bowels.

32. Upon receiving a complaint dated November 2018 did not report it to the local authority safeguarding team.

33. In your response to a complaint letter dated 14 December 2018 indicated that you had copied the CQC in when you knew had not

34. Your actions at charge 33 were dishonest in that you sought to create the impression that the CQC were being made aware of the complaint when you knew they were not

35. In your response to a complaint letter dated 21 January 2019 indicated that you had copied the CQC in when you knew you had not.

36. Your actions at charge 35 were dishonest in that you sought to create the impression that the CQC were being made aware of the complaint when you knew they were not.

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

Consensual Panel Determination

At the outset of this meeting, the panel was made aware that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the NMC and Mrs O'Brien.

The agreement sets out Mrs O'Brien's full admissions to the charges. It also sets out that Mrs O'Brien accepts that her fitness to practise is currently impaired. The provisional agreement proposes that a striking-off order would be the appropriate sanction.

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

That provisional CPD agreement reads as follows:

'The Nursing & Midwifery Council and Valerie Ellen O'Brien, PIN 77A4263E, ("the Parties") agree as follows:

1. *Ms O'Brien ("the registrant") is aware of the CPD meeting scheduled for 06 December 2021 and waives her right to the usual notice period in respect of this.*

The charges

2. *The registrant admits the following charges:*

That you a registered nurse, whilst acting as manager of the Lakeside Care Centre;

1. *In relation to service user A's prescription for Lorazepam did not ensure that guidance was provided to staff as to how service user A's anxiety presented.*

2. *In relation to service user B's prescription for metoclopramide did not ensure that instructions were provided as to why this would be administered.*

3. *In relation to service user B's prescription for eye drops did not ensure that guidance was provided as to whether both eyes required eye drops.*

4. *In relation to service user C's prescription for pain relief medication did not ensure that guidance as to whether the pain relief prescribed was to be given together or at separate times.*

5. *In relation to service user C's prescription cream did not ensure;*

    a. *that guidance was provided as to where the cream needed to be applied;*

    b. *that a body map was provided so that it could be marked as to where the cream was to be applied.*

6. In relation to service user D's transdermal patch did not ensure that records were maintained as to where the transdermal patch was applied.

7. .In relation to service user E 's prescription cream did not ensure;

a. that guidance was provided as to where the cream needed to be applied;
b. that a body map was provided so that it could be marked as to where the cream was to be applied.

8. *In relation to service user E did not ensure that the moving and handling risk assessment was always completed in that it did not include;*

a. The management plan for managing the risk;

b. The equipment used.

9. In relation to service user E did not ensure that a risk assessment was in place as to how staff would recognise one or more of the following conditions:

a. Hyperglycaemia;

b. Hypoglycaemia;

c. Epilepsy.

10. In relation to Service user E's care plan on promoting skin integrity did not

a. ensure that the record was updated since April 2018;

b. ensure that details were provided as to what constituted regular contact.

11. Did not ensure that service user E's care plan included the following information:

a. Prescription for apixaban.

b. Any potential risks that staff needed to be aware of in relation to the prescription for apixaban.

12. In relation to service user F's prescription cream did not ensure;

a. That guidance was provided as to where the cream was to be applied;

c. That a body map was provided so that it could be marked as to where the cream was to be applied.

13. In relation to service user G's prescription for eye drops did not ensure that guidance was provided as to whether both eyes required eye drops.

14. Did not ensure that guidance or a risk assessment was in place to support the practice of leaving doors open.

15. Allowed boxes of thickeners to be left in service user H's bedroom despite the containers displaying a notice stating 'do not leave at patients bedside'.

16. In relation to service user H risk assessment did not ensure that service user H was supervised during meal times.

17. In relation to service user H's challenging behaviour did not ensure that that there was a risk assessment in place to guide staff on how to

a. Manage the risks to themselves;

b. Manage the risks to service user H.

18. In relation to service user H's history of falls did not ensure that his falls risk assessment detailed;

a. That a sensor mat had been considered;

b. The reason why a sensor mat was deemed inappropriate.

19. Did not ensure that service user H;s care plan made reference to one or more of the following medical conditions:

a. Epilepsy;

b. Parkinsons disease.

20. In relation to Service users H's medical conditions referred to at charges 19 a, and or b did not ensure that the care plan reflected the following:

a. The level of support required

b. Whether any intervention was required

c. Whether any emergency action is required following a seizure.

21. In relation to an incident regarding manual evacuation of service user H's bowels did not investigate the matter properly in that you did not interview the key witness.

22. Did not ensure that service user H's mental capacity assessment was complete.

23. Did not ensure that service user H's MAR chart recorded the following information:

a. Whether service user H was able to consent to medication being crushed and given in yoghurt

b. Whether medication was to be given covertly.

c. If medication was to be given covertly did not record best interest decision to support the practice.

24. In relation to service user H's challenging behaviour did not;

a. Ensure that reference to his challenging behaviour was recorded in his care plan.

b. Ensure that a behavioural care plan was in place.

25. In relation to service user I who was perceived to be at risk of choking did not;

a. Ensure that their care plan referred to the risk of choking;

b. Ensure that their care plan referred to the level of supervision required.

26. In relation to service user J's PEG did not ensure that a risk assessment was in place

27. In relation to service user L who had sustained a number of falls did not ensure that any action to mitigate the risk of falling had been recorded

28. In relation to service user M's fall did not ;

d. Ensure that the injury was reported;

e. Ensure that the matter was investigated.

29. In relation to service user O did not ensure that their care plans referred to one or more of their following health conditions:

a. Epilepsy ;

b. Parkinsons disease.

30. Did not ensure that the home had an environmental risk assessment.

31. In relation to staff training

a. Did not keep records to demonstrate which members of staff had completed their induction;

b. Did not ensure that a system was in place which outlined what training was required for each role;

c. Did not include training certificates for all the training recorded on the training matrix;

d. Did not ensure that SM7's had received moving and handling training;

e. Did not ensure that SM8 who was the designated moving and handling trainer had received the appropriate training to deliver training;

f. Did not ensure that SM4 was competent to carry out a digital evacuation of service user H's bowels.

32. Upon receiving a complaint dated November 2018 did not report it to the local authority safeguarding team.

33. In your response to a complaint letter dated 14 December 2018 indicated that you had copied the CQC in when you knew had not.

34. Your actions at charge 33 were dishonest in that you sought to create the impression that the CQC were being made aware of the complaint when you knew they were not.

35. In your response to a complaint letter dated 21 January 2019 indicated that you had copied the CQC in when you knew you had not.

36. Your actions at charge 35 were dishonest in that you sought to create the impression that the CQC were being made aware of the complaint when you knew they were not.

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

Agreed facts

3. *The registrant's name was entered in the NMC register in 1980. She began working at Lakeside Nursing Home ("the Home") as a Home Manager in 2011. The Home provides care for up to 53 older people across three floors. The Home was inspected by the Care Quality Commission ("CQC") in August 2015 and received a 'good' rating. Inspections for services rated good were then pushed back by CQC which resulted in the service not been inspected again until January 2019. Prior to this the Clinical Commissioning Groups ("CCG") Safeguarding Team conducted a quality assurance visit at the Home on 17 December 2018. During this visit, unspecified safeguarding concerns were identified by the team.*

4. *The Home was subject of routine inspections by the CQC on 9 and 10 January 2019 and 11 February 2019. Following these inspections, the Home received an 'inadequate' rating. The CQC subsequently put the Home in 'special measures' and de-registered the registrant from being a CQC Registered Manager. The CQC inspection detailed a number of concerns regarding the registrant's practice as home manager.*

5. *The registrant resigned from the Home in April 2019, and she has not worked as a registered nurse since that time. She has stated that this is due to both health reasons and personal caring responsibilities.*

6. *On 21 February 2019 the NMC received a referral from Buckinghamshire Clinical Commissioning Group regarding the registrant's fitness to practise and outlining the concerns with her management of the Home.*

7. *Ms 1, Inspector at the Care Quality Commission ("CQC") prepared a report and witness statement. Attached to these were a number of documents including the Notice of proposal to cancel the registrant's registration with 56 appendices. The notice is comprehensive of her concerns with the registrant's management of the Home and exhibits the corresponding relevant documentation relevant to the charges as set out below at paragraphs 9 to 47.*

8. *The registrant admits all the charges and accepts that her fitness to practise is currently impaired. In her case management form ("CMF"), sent to the NMC by her representative on 3 September 2021, she indicated that she accepted all charges in their entirety.*

Charge 1

9. *Service user A's MAR chart indicated they were prescribed Lorazepam 1mg tabs as required. The instructions stated "half a tablet to be taken at night for agitation. Use sparingly (max 2mg in 24hrs)". Whilst the medicine had not been administered at the time of the inspection, there was no guidance for staff as to how the anxiety presented to ensure the medicine was given for what it was prescribed for.*

Charge 2

10. *Service User B was prescribed metoclopramide to be taken three times a day when required. There were no instructions as to why this would be administered.*

Charge 3

11. *Service user B was prescribed eye drops. The instructions on the MAR chart were to put the drops in the affected eye(s). There was no guidance provided as to whether this was both eyes or not. This had the potential for service users eye drops not to be administered for the purpose they were prescribed.*

Charge 4

12. *Service user C was prescribed a number of pain relief medicines as required, including paracetamol 500mg; morphine sulphate 5mg; and tramadol 50mg. There was no guidance as to whether these would be given together or if one was to be given first and then if the pain did not subside to administer the other analgesic.*

Charge 5

13. *Service user C was prescribed creams and lotions. The directions on the MAR chart was to apply as directed/when required. However, there was:*

    a. *no indication in the records where the cream needed to be applied*

    b. *no body charts were in use to provide this detail.*

Charge 6

14. *Service User D's MAR showed they were prescribed Fentanyl transdermal patches. At the inspection, the deputy manager confirmed records were not maintained as to where the transdermal patch was applied to ensure staff rotated the patch on each application to prevent the risk of skin irritation. After the inspection the registrant provided evidence that these records had been introduced but when this was reviewed, they were incomplete.*

Charge 7

15. *The direction on the MAR chart for service user E was to apply their prescription cream as directed/when required. However, the registrant did not ensure:*

    a. *That there was an indication in the records as to where the cream needed to be applied*

    b. *That a body map was provided so that it could be marked as to where the cream was to be applied*

Charge 8

16. *Service user E's care plan contained risk assessments in relation to risks associated with falls, pressure areas, use of bed rails, malnutrition and moving and handling. The moving and handling risk assessment was not always completed to include:*

    a. *The management plan for managing the risk*

    b. *The equipment used.*

Charge 9

17. *Service user E had a diagnosis of diabetes. Their care plan made brief reference to their diabetes but it did not outline how staff would recognise:*

    a. *Hypoglycaemic;*

    b. *A hyperglycaemic coma*

    c. *Epilepsy*

    and the emergency action to take.

Charge 10

18. *Service user E's care plan on promoting skin integrity indicated the service user had an air flow mattress in place and they were to be monitored regularly during personal care. There was no detail on what constituted regular monitoring and their on-going wound assessment record had not been not completed since April 2018.*

Charge 11

19. *Service users had care plans around their prescribed medicines. However, the care plans failed to make reference to:*

    a. *Service user E's prescription for Apixaban*

b. Any potential risks that staff needed to be aware of and respond to.

Charge 12

20. The direction on the MAR chart for service user F was to apply their prescription cream as directed/when required. However, the registrant did not ensure:

a. That there was an indication in the records as to where the cream needed to be applied

b. That a body map was provided so that it could be marked as to where the cream was to be applied

Charge 13

21. Service user G was prescribed eye drops. The instructions on the MAR chart were to put the drops in the affected eye(s). There was no guidance provided as to whether this was both eyes or not. This had the potential for service users eye drops not to be administered for the purpose they were prescribed.

Charge 14

22. Prior to the inspection concerns were raised that the doors between floors were left open and this put service users at risk of accessing the stairs and lifts without staff supervision. Service user G had partial sight which increased the risk of injury to them as they were at risk of leaving through the open door that led to the stairs.

23. The inspectors asked the registrant for guidance or a risk assessment to support the practice of leaving those doors open. She informed the inspectors none was in place.

Charge 15

24. Service user H had a risk assessment on the storage of thickeners in their bedroom but it lacked detail as to how the risks of this practice were mitigated. In service user H's bedroom an inspector observed they had four boxes of thickeners left on top of their bedside table. Three of those were for other service users and one belonged to

service user H. The product carried a notice 'do not leave at patient's bedside' on each container. This was immediately fed back to the registrant to act on and she was shown the patient safety alert, which indicated that service user H was at 'risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder'.

Charge 16

25. *On day 2 of the inspection a risk assessment had been put in place for service user H which was dated the day before (day one of the inspection). It indicated service user H was at risk of choking and they were to be supervised with their meal. The risk assessment did not outline the level of supervision required. The speech and language therapist meal time information sheet dated 27 September 2018 indicated service user H should be supervised at all times when eating. The inspector saw service user H was given their meal in their bedroom and no staff supervision was provided throughout.*

Charge 17

26. *Service user H's records showed they presented with challenging behaviours. Daily records showed a recent escalation in their behaviour, which resulted in staff being physically and verbally abused. The daily records made reference to recording challenging behaviour incidents but there was no risk assessment in place to:*

    a. *guide staff on how to manage the risks to themselves*

    b. *guide staff on how to manage the risks to service user H.*

Charge 18

27. *Service user H had sustained a number of falls. Whilst these were recorded there was no indication or what action the registrant had taken to mitigate the risks. An accident report for service user H indicated that a sensor mat would be put in place, however this had not happened. The registrant told the inspectors it was considered not appropriate. Service user H's falls risk assessment did not show:*

a. *that equipment such as a sensor mat had been considered*

b. *the reason why a sensor mat was deemed inappropriate.*

Charge 19

28. *Service user H had medical conditions such as epilepsy and/or Parkinsons disease. Their care plans made no reference to these conditions or the level of support and intervention require, including any emergency action following a seizure*

Charge 20

29. *Service user H's care plan indicated that they were at risk of choking and they were to be supervised with their meal. The speech and language therapist meal time information sheet dated 27 September 2018 indicated service user H should be supervised at all times when eating. The care plan did not reflect:*

    a. *The level of supervision required.*

    b. *Whether any intervention was required*

    c. *Whether any emergency was required following a seizure*

    The inspector saw service user H was given their meal in their bedroom and no staff supervision was provided throughout.

Charge 21

30. *Service user H had an entry in their communication record which detailed that a digital evacuation of their bowel had been carried out. Their elimination plan made no reference to this being required, justified or agreed with professionals involved in this service user's care.*

31. *The action described on the notification to the commission was an invasive procedure that would require evidence of it having been justified and agreed with the service user and medical staff involved in service user H's care. At the request of the local authority*

safeguarding team the registrant subsequently carried out an investigation into the incident. The outcome was that no disciplinary action would be taken against SM4. The registrant concluded her investigation without interviewing the key witness, namely the other staff member present during the incident.

Charge 22

32. *In service user H's file, it was recorded they had limited capacity but it referred to service user H needing support with complex decisions. Their mental capacity assessment was incomplete so it was not established how staff had concluded that service user H had limited capacity or what areas they needed support with.*

Charge 23

33. *Service user H's medicine administration record indicated that one of their medicines was to be crushed and given in yoghurt. There was no indication as to whether the service user H was:*

    a. *able to consent to this or was it being administered covertly.*

    b. *whether the procedure was to be given covertly*

    c. *if given covertly there was no best interest decision to support the practice and therefore the service was not acting in accordance with the requirements of the mental capacity act 2005 and associated code of practice.*

Charge 24

34. *A challenging behaviour record was in place which showed service user H had been physically and verbally aggressive to staff. The registrant did not ensure that:*

    a. *challenging behaviours were recorded in service user H's care plan*

    b. *reference to service user H's behavioural care plan was in place to provide consistent guidance on how service user H was to be supported.*

Charge 25

35. *At lunch time on day one of the inspection the inspectors observed service user I was provided with a soft diet and they had a thickener in their drink, as they were perceived to be at risk of choking. Throughout the meal time the inspectors observed service user I fed themselves and no staff supervision was provided. The care plan made no reference to:*

    a. *the risk of choking*

    b. *the level of supervision required.*

36. *The inspectors pointed this out to the registrant and staff members but the inspectors saw no supervision was provided to service user I on day two of the inspection either.*

Charge 26

37. *The inspectors saw service user J took all of their nutrition via percutaneous endoscopic gastrostomy (PEG). A risk assessment was not in place to address the risks of issues such as the feeding tube becoming detached or blocked or risk of infection at the stoma site*

Charge 27

38. *Service user L had sustained a number of falls. Whilst these were recorded there was no indication that the registrant has taken any action to mitigate the risks.*

Charge 28

39. *The accident records viewed showed that the bed sides in Service user M's bed had not been put up to promote their safety. Service user M subsequently fell out of bed. In relation to the fall:*

    a. *No injury was reported although their daily records showed they had complained of pain in their right wrist the following day*

b. *There was no indication that the incident was appropriately investigated and lessons learnt.*

Charge 29

40. *Service user O had epilepsy and Parkinson's Disease. Their care plans made no reference to these conditions or the level of support and intervention required, including any emergency action following a seizure.*

Charge 30

41. *The inspectors asked the registrant for the environmental risk assessment for the service. She informed the inspectors that one was not in place and therefore the environmental risks to service users, visitors and staff were not identified and mitigated. Throughout the inspection the inspectors observed moving and handling hoists were left in the corridors on each floor. This had the potential to act as a hazard. The service had not considered if this posed a risk to service users the inspectors raised this as concerns with the registrant and the provider.*

Charge 31

42. *The registrant told the inspectors she audited staff files. She had a matrix to enable her to audit when staff supervisions had been carried out and to record when training had taken place. Staff members were designated moving and handling trainers. However, the audit was ineffective as:*

    a. *records to demonstrate which members of staff had completed their induction*

    b. *there was no system was in place which outlined what training was required for each role*

    c. *training certificates were not available for all the training recorded on the matrix and supervision of staff was not taking place in line with the Home's policy*

d. *The inspectors found evidence that SM7 did not always follow guidance on how to safely support a service user to move position. Where this had occurred, the registrant failed to act appropriately and investigate the actions taken by SM7. A safeguarding alert was not completed and SM7's training records did not evidence that they had moving and handling training provided before or as a result of this incident*

e. *The deputy manager and SM8 were designated moving and handling trainers. There was no certificate on file to indicate they had the required training and skills to deliver this training. SM8 told the inspector that their training was out of date but could not recall when they had it or when it had expired. The registrant told the inspectors she had arranged for six staff to be trained as moving and handling trainers but this training was not booked until the 25 March 2019. This meant that service users' safety was compromised as none of the staff had up to date moving and handling training*

f. *Registered nurse SM4 carried out a digital evacuation of service user H's bowels. Nurse SM4 had no competency assessment on their training file to demonstrate that they were up to date with guidance and could justify the rationale for this procedure as outlined by the national institute for health and care excellence (NICE guidance). The registrant told the inspectors that the service did not carry out digital evacuations and that she was unaware that this practice was taking place. The inspectors asked her to make a safeguarding alert in respect of this incident. After the inspection she completed a notification to the commission which she disputed the entry written in service H's records. The registrant informed the commission that the registered nurse SM4 who had carried out the procedure confirmed they had not carried out a digital evacuation but did not know how to record the action they had taken.*

Charge 32

43. *A complaint dated November 2018 with an allegation of neglect was not perceived as potential safeguarding concerns and not reported to the local authority safeguarding team.*

Charge 33

44. *In the registrant's response to a complaint dated 14 December 2018, she indicated that she had copied the CQC into her response to the complaint. No record of the CQC being copied into the response was found. The complaint was picked up at the inspection as an allegation of neglect and the complaint information was sent to the commission following the third day of inspection on 11 February 2019.*

Charge 34

45. *The registrant's actions at charge 33 above were dishonest.*

Charge 35

46. *The registrant indicated that she had copied the CQC into her response to a complaint letter dated 21 January 2019. As per charge 33 above, no record of the CQC being copied into the response was found, and the complaint was picked up during inspection on 11 February 2019.*

Charge 36

47. *The registrant's actions at charge 35 above were dishonest.*

Misconduct

48. *The misconduct in this case relates to concerns regarding poor management; failure to ensure staff training; failure to investigate, report and escalate incidents appropriately; failure to promote safe medicines practices and manage risks; and dishonesty. The areas of concern identified are serious, numerous and wide-ranging, and fall short of what is expected of a registered nurse. The failings involve a serious departure from expected standards, and put patients at risk of harm. These failings are likely to cause risk to patients in the future if they are not addressed.*

49. *The following paragraphs of the 2015 NMC Code of Conduct have been breached:*

> ***1.2*** *Make sure you deliver the fundamentals of care effectively*
>
> ***2.1*** *work in partnership with people to make sure you deliver care effectively*
>
> ***6.2*** *maintain the knowledge and skills you need for safe and effective practice*
>
> ***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*
>
> ***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*
>
> ***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*
>
> ***16.1*** *raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your*

workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.4 *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*

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

19.2 *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)*

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

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

20.2 *act with honesty and integrity at all times…*

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

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*

50. *It is accepted that not every breach of the Code will result in a finding of misconduct however, the registrant's failings are numerous and amount to a serious departure from the professional standards and behaviour expected of a registered nurse.*
51. *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 and therefore it is imperative that nurses make*

sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

52. *The registrant's failings fell far below the standards expected of a registered nurse and all the charges found proved are sufficiently serious so as to amount to misconduct.*

Impairment

53. *In relation to impairment, the general approach to what might lead to a finding of impairment was provided by Dame Janet Smith in her Fifth Shipman Report. A summary is set out in the case of CHRE v NMC & Grant [2011] EWHC 927 at paragraph 76 in the following terms:*

> *"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 should also consider the comments of Cox J in Grant at paragraph 101:

> *"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a*

finding of impairment of fitness to practise were not made in the circumstances of this case."

In this case, limbs a, b, c and d are engaged.

54. *The registrant's misconduct put patients at unwarranted risk of harm. Patients and members of the public would be concerned to hear of such wide-ranging failings in a nurse's management of a care home caring for vulnerable elderly people. The registrant's failures have brought the profession into disrepute. Nurses are placed in a position of trust, to care for and protect the people in their case. Such failings undermine that trust and breaches the fundamental tenets of the nursing profession.*

Remediation, reflection, training, insight, remorse

55. *The registrant has provided no evidence of remediation. She accepts the charges and admits that her fitness to practise is impaired therefore demonstrating limited insight. However, there is no evidence of any reflection to demonstrate that she has undertaken any meaningful reflective work, and no evidence of any steps taken to remediate her practice.*

56. *In Cohen v GMC [2007] EWHC 581 (Admin), 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*

57. *The three questions set out in Cohen (above) can be answered as follows:*

    1. *The regulatory concerns in this case are capable of remediation by way of training and satisfactory performance in the identified areas of concern.*
    2. *No evidence of remediation has been provided.*

3. *The concerns are highly likely to be repeated should the registrant be permitted to practise on an unrestricted basis.*

Public protection impairment

58. A finding of impairment is necessary on public protection grounds.

59. In the absence of full insight and remediation, the registrant is liable in the future to put patients at unwarranted risk of harm were she to practise without any restrictions.

Public interest impairment

60. A finding of impairment is necessary on public interest grounds.

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

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

62. The reputation of the nursing profession would be damaged if the registrant were to be permitted to practise unrestricted: the public expect nurses to be able to practise safely and deliver the appropriate care at all times, particularly those in management positions overseeing the care of numerous patients. The registrant's failures relate to core nursing skills and professional standards. In light of these failings, a finding of current impairment is necessary to declare and uphold proper standards.

63. For the reasons above, the registrant's fitness to practise is currently impaired by reason of his misconduct, on both public protection and public interest grounds.

Sanction

64. Whilst sanction is a matter for the panel's independent professional judgment, the appropriate sanction in this case is ***a striking-off order.***

65. In determining sanction, the panel should have regard to the NMC's Sanctions Guidance ('the Guidance'), bearing in mind that it provides guidance and not firm rules. The panel will be aware that the purpose of sanctions is not to be punitive but to protect the public and public interest. The panel should take into account the principle of proportionality and it is submitted that the proposed sanction is a proportionate one that balances the risk to public protection and the public interest with the Registrant's interests.

66. The aggravating features of the case are as follows (this list is non-exhaustive):

- *Risk of harm to patients*
- *No evidence of insight or remediation*
- *Pattern of misconduct over a period of time*

67. The mitigating features of the case are as follows (non-exhaustive):

- *The registrant accepted the concerns in full.*

68. In taking the available sanctions in ascending order, the panel must first consider whether to take no action or make a caution order. The parties agree that neither of these would be appropriate in view of the seriousness of the misconduct, the need to protect the public interest and the need to declare and uphold proper standards of conduct.

69. With regard to a conditions of practice order, the concerns in this case are wide-ranging and there is evidence of misconduct over a prolonged period of time. The registrant has not demonstrated insight and has not taken steps to remediate her practice. However, the concerns are so serious and wide-ranging, that a conditions of

practice would not adequately address the public protection and public interest concerns identified. Further, the registrant has not demonstrated a willingness to engage with conditions of practice and has indicated that she does not wish to return to nursing practice. In the circumstances, a conditions of practice order would not adequately address the risks in this case.

70. *The parties next considered a suspension order. A suspension order would restrict the Registrant's practice and uphold the public interest. However, given the serious and repeated nature of the misconduct, such an order would not mark the seriousness of the conduct in question and would not be sufficient to uphold trust and confidence in the profession and the regulatory process.*

71. *The parties determined the appropriate sanction is a striking off order. A striking off order would uphold trust and confidence in the profession. Having regard to the NMC Sanctions Guidance, the regulatory concerns raise fundamental questions about the Registrant's professionalism. Public confidence in the profession would be undermined by any lesser sanction and a striking off order is the only sanction which will be sufficient to protect patients, members of the public, and maintain professional standards.*

72. *The imposition of a striking off order adequately reflects the seriousness of the circumstances underlying the misconduct where a suspension order would not sufficiently do so.*

Interim order

73. *The parties agree that, should the panel agree with the proposed sanction, the panel should also make an interim suspension order, under Article 31(1)(c) of the Nursing and Midwifery Order 2001, on the grounds that it is necessary to protect the public and is otherwise in the public interest. This order, which should be for a period of 18 months to cover the appeal period, will fall away at the end of that period if there is no appeal. The parties agree that such an order is necessary to protect the public and is otherwise in the public interest for the reasons set out in relation to sanction, above.*

74. The parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.'

Here ends the provisional CPD agreement between the NMC and Mrs O'Brien. The provisional CPD agreement was signed by the RCN, on behalf of Mrs O'Biren, and the NMC on 26 November 2021.

Decision and reasons on the CPD

The panel decided to accept the CPD.

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

The panel noted that Mrs O'Brien was legally represented and had admitted the facts of the charges against her. Accordingly, the panel was satisfied that the charges are found proved by way of Mrs O'Brien's admissions as set out in the signed provisional CPD agreement.

The panel was therefore satisfied that the facts are proved in this case.

Decision and reasons on misconduct and impairment

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

In respect of misconduct, the panel determined that the conduct was very serious in this case. The panel noted that the misconduct in this case relates to a number of concerns, including: poor management; failure to ensure staff training; failure to investigate, report and escalate incidents appropriately; failure to promote safe medicines practices and manage risks; and dishonesty. The panel concluded that the areas of concern identified were serious, numerous and wide-ranging, and fall short of what is expected of a registered nurse. It was particularly concerned about the significant element of dishonesty. The panel was of the view that Mrs O'Brien's conduct breached several areas of the Code as highlighted within paragraph 49 of the CPD agreement. The panel therefore determined that Mrs O'Brien's actions amounted to misconduct.
In this respect, the panel endorsed paragraphs 49 to paragraph 52 of the provisional CPD agreement in respect of misconduct.

The panel then went on to consider whether Mrs O'Brien's fitness to practise is currently impaired by reason of misconduct. The panel determined that Mrs O'Brien's fitness to practise is currently impaired. The panel noted that there was no information before the panel to demonstrate that Mrs O'Brien has remediated her practice. It noted that there are no reflections or any information to suggest that Mrs O'Brien has understood the gravity of what occurred, has addressed any of the concerns identified or demonstrated what she would do differently if she faced similar circumstances in the future. The panel therefore determined that there remains a high risk of repetition and Mrs O'Brien's fitness to practise remains impaired on the grounds of public protection and the wider public interest.

In this respect the panel endorsed paragraphs 53 to paragraph 63 of the provisional CPD agreement.

Decision and reasons on sanction

Having found Mrs O'Brien's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate. 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:

- Risk of harm to patients
- No evidence of insight or remediation
- Pattern of misconduct over a period of time

The panel also took into account the following mitigating features:

- The registrant accepted the concerns in full.

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.

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 and public interest issues identified, an order that does not restrict Mrs O'Brien's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel*

wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Mrs O'Brien's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

The panel then went on to consider whether a suspension order would be an appropriate sanction.

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

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in considering a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*

- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

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

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

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.
This will be confirmed to Mrs O'Brien in writing.

Decision and reasons on interim order

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

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

The panel agreed with the CPD that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow time for the striking off order to come into effect or to cover the period for any appeal.

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

That concludes this determination.