Nursing and Midwifery Council

Voluntary Removal Decision

Dated 16th September 2020

Registrant: Bernadette Edith Ellen O'Neil

PIN: 88B0382E

Part(s) of the register: Registered Nurse – sub part 2 Adult Nursing (April 1990)
Area of Registered Address: England

Type of case: Misconduct

REGISTRAR'S DECISION –

1. A decision has been made by the Registrar to approve the application for voluntary removal based on the assessment of the relevant criteria. The reasons for the decision to grant voluntary removal from the Register are below.

Details of charge

That you, a registered nurse, whilst employed/operating as the Registered Manager of Finch Manor Nursing Home ("the Home") between August 2015 and November 2017;

1. Failed to ensure the safe management and administration of medication to Service Users, in that you,

1.1 Failed to take appropriate action when Service User B refused to take prescribed medication.

1.2 On 17 May 2017 could not demonstrate knowledge of how medications were managed in the home.

1.3 Did not ensure staff could adequately use the electronic medication system (Emar).

1.4 Could not account for 37 mls of Haloperidol going missing for Service User S between April and May 2017.

1.5 Between April and May 2017 did not ensure that Service User T had been administered 16 doses of prescribed Braltus (tiotroipim).

1.6 Between 12 and 17 May 2017 did not ensure that Service user T was administered prescribed Eurax Cream.

1.7 Between 15 and 16 May 2017 did not ensure that Service User N received Nystatin Liquid within a timely manner after the out of hours Doctor prescribed the medication.

1.8 Did not ensure that care co-ordinators were not administering Flucloxacillin to Service User T at meal times.

1. 9 Did not ensure that care co-ordinators were administering Dexamethasone for Service User U every 12 hours.

1.10 Did not ensure that service user U's thickening agents were administered in an adequate manner.

1.11 On 17 May 2017 did not ensure Service User T's medication was disposed of safely.

1.12 Did not ensure that unwanted medicine was stored safely in a locked cupboard.

1.13 Did not ensure that medication requiring cold storage were stored at the correct temperature.

1.14 Did not ensure that all Service Users could be identified by photographs on the electronic system.

1.15 Did not ensure that the medication policy had been updated to give guidance on the new electronic system.

1.16 Did not ensure there was a system in place to show nurses could delegate the task of administering medicines to non-nursing staff.

1.17 In November 2017 did not ensure that Service User A's MAR charts were completed accurately.

2. Failed to ensure adequate care planning, record keeping and risk assessment for Service Users, in that;

2.1 Service User A's care plan contained insufficient information to enable them to be provided with adequate care.

2.2 On 17 May 2017 Service User A's nutritional care plan was not followed adequately.

2.3 Service User B's care file contained insufficient information regarding prescribed medication.

2.4 Service User B's care plan contained inadequate information regarding their capacity assessments.

2.5 Service User B's behavioural changes were not risk assessed/monitored or acted upon.

2.6 Service User B's mental health and non-compliance with the medication regime were not referred to the local authority and safe guarding team.

2.7 On 17 May 2017 Service User C's care plan was not followed.

2.8 Service User D's care file contained insufficient information regarding;

2.8.1 Service User D's Epilepsy
2.8.2 Service User D's Low Salt Diet
2.8.3 Service User D's Blood Pressure

2.9 Service User D's blood pressure was not monitored on a regular basis.

2.10 Service User E's care plan contained insufficient information to provide them with adequate care.

2.11 Staff did not ensure that Service User A's daily fluid requirements and dietary needs were met

2.12 Staff were unaware of what texture of diet was safe for Service User B

2.13 Staff were unaware of what texture of diet was safe for Service User F

2.14 Staff did not use the Waterlow Risk Screen Assessment for risk to skin integrity tool adequately for Service User D.

2.15 Service User D's dependency assessment dated 29 March 2016 was incomplete

2.16 Staff did not monitor/adequately review Service User D's bowel actions as required by his personal care plan.

2.17 You did not ensure that a risk assessment for epilepsy was in place for Service User D.

2.18 Service User E's care file was inadequate as;

2.18.1 The care plan for manual handling dated 21 May 2017 did not contain a moving and handling risk assessment.

2.18.2 The care plan for manual handling dated 12 May 2017 did not reflect moving and handling advice from the NHS community physiotherapist service.

2.18.3 The choking risk assessment dated 15 May 2017 did not adequately assess the risk of choking.

2.19 In November 2017 Service User D's care plan had been amended to stated "Reported to no longer have epilepsy" without an explanation or review of Service User D's care plan.

2.20 Between May and November 2017 Service User D's care planning did not improve.

2.21 Staff inaccurately recorded that 52 nutritional supplements were given to Service User CC1.

2.22 Between September and November 2017 Service User CC1's food and fluid intake resulted in his deterioration.

2.23 Service User care plan date 30 October 2017 did not include the prescribed nutritional supplements and information of reduced food and fluid intake.

3. Failed to ensure a safe number of competent, trained nursing staff as;

3.1 Only 3 out of 54 nursing and care staff listed at the home had received any training in nutrition.

3.2 You did not ensure there was a system in place to enable staffing levels to safely meet the needs of service under your care.

3.3 You did not ensure that the number of care or nursing staff were sufficient in number or deployed effectively.

3.4 Only 3 out of 7 nursing staff had completed the mandatory training required by the home.

3.5 You did not ensure that all nursing staff had an appraisal of their skills and competencies.

3.6 You did not ensure that the Home's recruitment policy and/or safe recruitment decisions were followed, in that you;

3.6.1 Did not ensure that information surrounding (L. Scott) C6's previous suspension was adequately investigated.

3.6.2 Did not ensure that (L. Scott) C6's DBS risk assessment was adequately completed.

3.6.3 Did not ensure Colleague CC1's employment application was kept on file.

3.6.4 Did not ensure Colleague CC1's Employment/Work Reference dated 23.06.16 was adequately risk assessed.

3.6.5 Did not ensure Colleague CC1 was promoted to a Care Co-Ordinator with the necessary skills and competency

3.6.6 Did not ensure that Colleague C3's Employment/Work Reference dated 22.09.2106 was adequately risk assessed.

3.6.7 Did not ensure that Colleague C4's Work/ Employment References' were adequately risk assessed.

3.6.8 Did not ensure that Colleague N4's pending disciplinary action with his previous employers had been sufficiently investigated.

4. Failed to ensure a safe living environment for residents, as;

4.1 On 17 & 19 May 2017 Service User A was not provided with a pressure relief cushion to maintain skin integrity

4.2 You failed to ensure that Service User A provided legal consent for;

4.2.1 Use of bed rails
4.2.2 The administration of covert medication

4. 3 Service User A's handling risk assessment/moving handling plan contained inadequate information surrounding Resident A's Osteoporosis and Polymyalgia.

4.4 On 17 & 19 May 2017 staff used methods to move Service User A contrary to the information contained in their care plan.

4.5 In May 2017 you failed to conduct a review/re-assessment of Service User A's moving and handling care needs.

4.6 Staff failed to ensure that thyroid function tests for Service User A were conducted as per geriatrician advice.

4.7 Staff did not comply with medical advice in accordance with Service User A's nutritional intake.

4.8 Staff did not conduct clinical observations regarding Service User A's ankle Odema and Tachycardia.

4.9 Between 17 & 19 May 2017 Service User C was not provided with a pressure relief cushion to maintain skin integrity.

4.10 On 17 & 19 May 2017 Service User C was observed mobilising without any mobility aids.

4.11 Service User D was allowed to access the community independently without staff support, in contradiction to his Mental Capacity Assessment dated 29 March 2016.

4.12 Service User D's capacity to consent to care and treatment under sedation was not conducted.

4.13 Service User E's care file did not contain a moving and handling risk assessment.

4.14 Service User E's care file did not appropriately assess the risk of choking.

4.15 Wound assessments conducted by staff lacked adequate information in that;

4.15.1 Service User F's wound evaluation form did not contain adequate information about their wound.

4.15.2 Service User H's wound evaluation form did not contain adequate information about their wounds.

4.15.3 Service User F's wound evaluation form did not contain adequate information about their wounds.

4.15.4 Service User D's wound care plan was completed inadequately

4.16 Staff did not record that they had checked/assessed Service User F's wound dressing daily as required by the wound management plan.

4.17 Staff did not record that they had checked/assessed Service User H's wounds on a daily basis.

4.18 Between 20 April 2017 and 22 May 2017 staff did not record that they had checked/assessed Service User I's wound on a daily basis.

4.19 Staff did not follow Service User I's care plan as they failed to conduct 2 hourly checks for Service User I's well-being on;
4.19.1 5 May 2017
4.19.2 7 May 2017
4.19.3 8 May 2017
4.19.4 10 May 2017
4.19.5 12 May 2017
4.19.6 14 May 2017

4.20 Staff did not ensure Service User I's pressure mattress was appropriate to Service User I's weight on 22 May 2017.

4.21 Service User I's weight chart did not show how their food intake would be recorded

4.22 In November 2017 Service User I's nutritional care plan had not been updated since 22 May 2017 despite significant weight loss

4.23 Service User I's diet had not been escalated from a regular diet to a fortified diet as required by her care plan.

4.24 Staff had not completed Service User I's Malnutrition Universal Screening Tool Document adequately.

4.25 Between 24 July 2017 and 7 November 2017 Service User I's diet was not escalated for a dietician referral.

4.26 Service User J's daily records for Bed Rail Check/ Mattress Check/ Turns were completed on;

4.26.1 5 May 2017
4.26.2 9 May 2017

4.27 Service User X's personal care chart did not show that they had been supported to have bath or shower for a period of 15 days between 1 May 2017 and 16 May 2017.

4.28 Service User Y's personal care chart did not show that they had been supported to have a bath or a shower for a period of 8 days between 1 May 2017 and 9 May 2017

4.29 Service User Z's personal care chart did not show that they had been supported to have a bath or a shower for a period of 14 days between 1 May 2017 and 15 May 2017

4.30 You did not ensure that adequate fire procedures were in place at the home.

4.31 Personal Emergency Evacuation Plans were not in place for all residents at the home.

4.32 You did not conduct an individual fire risk assessment for each resident in the home.

4.33 Between May 2016 and Mach 2017 you did not take adequate action to resolve complaints about the quality and quantity of food provided at meal times.

4.34 Between January 2017 and April 2017 an audit of service user SC's care file identified that their nutritional risk assessment had not been reviewed.

4.35 Service user SC's skin integrity risk assessment was out of date.

4.36 Service User MH's risk assessment and personal care plan required updating.

4.37The medication audit dated 6 May 2017 was completed incorrectly.

4.38 Between 24 March 2017 and 24 April 2017 14 service users missed their medication.

4.39 Between 24 April 2017 and 17 May 2017 17 service users missed their medication.

5. Failed to ensure proper disposal of confidential patient material and medication, as;

5.1 On 17 of May 2017 CQC inspectors found confidential patient material in a skip outside the home.

5.2 On 17 May 2017 CQC inspectors found two bags of unsecure medication waste in a skip outside the home.

And, in light of the above, your fitness to practice is impaired by reason of your misconduct.

REGISTRAR'S REASONS

2. The following documents were considered when assessing this voluntary removal application:

- Voluntary removal application form dated 10 July 2020
- Draft charge
- Letter from Representative dated 11 December 2017
- Regulatory response form dated 19 February 2018
- Regulatory response form dated 20 October 2018
- Case Management Form dated 14 Feb 2019
- Ms O'Neil's reflective statement received July 2020
- Medical evidence
- CE decision letter dated 5 December 2018
- Previous voluntary removal applications
    - Voluntary removal application form dated 9 Feb 18
    - Voluntary removal application form dated 4 Feb 19
    - VR Recommendation and Registrar's decision, dated 18 March 2019
- Response from Kerry Cupit of the CQC, the maker of the allegation, dated 26 February 2019

Background

3. The relevant background status:

- The registrant, Bernadette Edith Ellen O'Neil, ("Ms O'Neil") submitted an application to be voluntarily removed from the NMC register.

- Ms O'Neil is currently the subject to an interim suspension order.

Factual background to the allegations

4. The relevant facts are:

- A referral was made by the CQC in November 2017 in which they raised concerns about Ms O'Neil's fitness to practise.

- The concerns relate to the time Ms O'Neil was the Registered Manager at Finch Manor Nursing Home (the Home)

- Ms O'Neil was the Registered Manager of the Home from August 2015 to October 2017. In May 2017, the CQC inspected the Home and rated it as inadequate. They carried out a follow-up inspection in October/November 2017, and again rated the Home inadequate.

- It is alleged, that, Ms O'Neil, as the Registered Manager at this time, was responsible for the failings identified.

- The regulatory concerns identified by the NMC are:
    - failed to ensure the safe management and administration of medication to residents
    - failed to ensure adequate care planning, record keeping and risk assessment for residents
    - failed to ensure a safe number of competent, trained nursing staff
    - failed to ensure a safe living environment for residents
    - failed to ensure proper disposal of confidential patient material

Nature of the allegations

5. The fitness to practise case relates to misconduct allegations

    - The draft charge is attached

    - The Case Examiners considered this case on 30 November 2018 and decided there was a case to answer. The matter was referred to the Fitness to Practise Committee.

Public interest considerations

6. The public interest considerations that I have taken into account:

- The allegations relate to wide ranging failures in the management of the Home over a significant period of time. Ms O'Neil was the Registered Manager of the Home from August 2015 to October 2017. This is primarily a public protection concern in that Ms O'Neil's failures placed multiple residents at a high risk of harm. Also relevant is the public interest, given the charges relate to poor care of vulnerable residents over a prolonged period of time

- Initially Ms O'Neil accepted that some of the concerns raised were accurate but denied responsibility for the failings and sought to deflect blame by shifting responsibility onto others.

- Ms O'Neil made an application for voluntary removal on 4 February 2019 in which she admitted some of the allegations and that her practise was impaired by way of her health, not her misconduct.

- But Ms O'Neil, in her completed case management dated 14 February 2019, submitted at the same time as her voluntary removal application dated 4 February 2019, disputed the facts of the allegations and that her fitness to practise was impaired.

- The allegations in this case are serious, the NMC guidance states that serious concerns which are more difficult to put right include being directly responsible (such as through management of a service or setting) for exposing patients or service users to harm or neglect.

- The aggravating features at the time of the application in February 2019 could be said to include.

    - *lack of insight into failings*

    - *a pattern of misconduct over a period of time*

    - *conduct which put patients at risk of suffering harm.*

- Taking the seriousness of the allegations and the aggravating features into account Ms O'Neil's conduct could be seen as being incompatible with continued registration. At the time the NMC sanction bid was a striking off order as being the most proportionate sanction to protect the public and uphold confidence in the profession.

- The NMC's guidance on voluntary removal is clear:

    - *The only circumstances in which we'll accept applications for VR are:*

        - *the nurse, midwife or nursing associate accepts the regulatory concern(s);*

        - *the regulatory concerns are not so serious that they are fundamentally incompatible with being a registered professional; and*

        - *the nurse, midwife or nursing associate provides evidence that they do not intend to continue practising.*

- Based on this guidance, at the time of the application in February 2019 it was not appropriate to allow Ms O'Neil to remove herself from the register by way of voluntary removal. The public interest in allowing a panel consideration of the serious and disputed allegations was such that the public confidence in the NMC as a regulator could have been damaged in allowing Ms O'Neil to remove herself from the register.

- Since that time Ms O'Neil's insight has developed and she now accepts the facts of the allegations and that her fitness to practise is impaired by way of her misconduct. In support of her most recent voluntary removal application Ms O'Neil submitted a detailed reflective statement in which she accepts she was accountable for the failings of the Home, stating:

    - *"I have never knowingly put the reputation of the profession into disrepute, however, upon reflection I accept that my behaviour and failures did indeed do this at the time of the referral. My fitness to practice is impaired and will continue to be so.*

      With this said, I was accountable for the failings of the home and therefore accept the charges laid against me by the NMC."

- Referring to the NMC sanction guidance the allegations remain serious and difficult to put right. However, taking into account Ms O'Neil's submissions in support of this voluntary removal application the mitigating features can now be said to include:

    - *Evidence of Ms O'Neil's acceptance of the allegations and impairment*

    - *Evidence of Ms O'Neil's insight and understanding of the concerns raised*

    - *Personal mitigation, Ms O'Neil's health may have impacted on her practise and on her initial responses to the allegations.*

- Ms O'Neil has provided evidence of her poor health and is suffering from many health conditions. These conditions are referred to in submissions by Ms O'Neil's representatives dated 11 December 2017 and again in MS O'Neil's voluntary removal application dated 9 February 2018. The first evidence to support this as a possible diagnosis can be found in a letter from Peninsula Health, dated 10 April 2018. The diagnosis is then confirmed in a letter from Wirral University Teaching Hospital Trust dated 19 July 2018. Both letters raise the possibility that Ms O'Neil may have been suffering from some of these conditions for some time prior to the diagnosis.

- Although we cannot say to what level, if any, Ms O'Neil's condition impacted on her role as the Registered Home manager at the Home it may offer some mitigation for her actions, as she states in her reflection:

    - *"I had acknowledged in August 2016, that my health was not to the standard that was required to maintain the role of a Registered Home Manager. Neither was it to the standard of a Registered Nurse. I was unable to perform the basic duties of that as a registered nurse nor the responsibilities of a Registered Manager."*

- She goes on to state that she should have removed herself from the NMC's register at this time as well as deregistering as the Home's Registered Manager.

- Some consideration of the context of Ms O'Neil's health conditions should be made when considering her initial lack of meaningful insight and attempts to deflect blame onto others in her responses on being informed of the referral to the NMC. However, it is noted that Ms O'Neil doesn't use her health conditions as an excuse, in her reflective statement she states:

    - *"As stated my memory was, and still is, affected, however, saying 'I forgot' is not acceptable and for this I accept as being my fault."*

- Ms O'Neil now accepts the facts of the allegations and that her fitness to practise is impaired, the regulatory concerns are linked to management of clinical practice and care of vulnerable residents. The allegations are many, wide ranging and serious but can be considered remediable.

- Ms O'Neil has now shown insight and remorse. In her reflective statement Ms O'Neil states:

    - *"However, whilst I still have some windows of clarity and with the help of my daughter, I wanted to reflect upon this experience and to let you know that I am sorry for my failures and that I do accept accountability of what has happened."*

Comments from the maker of the allegations

7. We wrote to the matter of the allegations:

The maker of the allegations does not have any objections to the application for removal from the register, but was concerned about the Ms O'Neil's ability to register in the future.

Analysis

8. Taking the mitigating features into account, including Ms O'Neil's current level of insight, her conduct at this stage may not be considered incompatible with continued registration, and no longer warrant a striking off order for the following reasons:

- In her reflection, as well as showing acceptance of her responsibility as the Registered Home manager, she also demonstrates insight into the impact her health was having on her, stating:

    - *"I have also learnt that I should have asked for more help when my health started to deteriorate and allow myself to be guided by them. I just couldn't see I needed it."*

- Our primary role is to protect the public, not to be punitive. Allowing Ms O'Neil's immediate removal from the register by way of voluntary removal would be a more proportionate resolution than placing her on an ongoing sanction, a sanction to which she it seems she would be able to provide limited meaningful engagement, if any, would not be able to remediate her practise or provide further insight due to her deteriorating health.

- The NMC introduced 12 Fitness to Practise principles to ensure consistency and fairness in our decision-making. The following principle is particularly relevant to the circumstances of this case:

    2. Fitness to practise is about managing the risk that a nurse or midwife poses to patients or members of the public in the future. It isn't about punishing people for past events.

    If professionals see us as being punitive, those professionals are more likely to hide things going wrong or act defensively. This will make it difficult to achieve the kind of open and learning culture that's most likely to keep patients and members of the public safe.

- There is a clear public interest in encouraging open and honest admissions where things have gone wrong, Ms O'Neil has now made these admissions. Given all of the factors in this case the public interest in declaring and upholding professional standards and the maintenance of confidence in the profession can now be met without Ms O'Neil's case being adjudicated upon by a panel.

- This has been a difficult case to determine due to the seriousness of the charges, and the difficulty of balancing the public interest. However, I believe that Ms O'Neil's immediate removal from the register by allowing voluntary removal would be an appropriate conclusion and would not undermine public confidence in the regulatory process.

- It is noted that this application, if granted, will be published on the NMC website under new guidance effective from 21 October 2019. This further meets the public interest in that there will be a public record of the application and the outcome.

Registrar's decision

For the reasons set out above I approve this application for voluntary removal

Anthony Robinson

Assistant Registrar

Dated 16th September 2020