Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 5 September 2022 – Thursday 8 September 2022

Virtual Hearing

Name of registrant:	**Zanele Lisa Sibanda**
NMC PIN:	17I0673E
Part(s) of the register:	RNMH, Registered Nurse – Mental Health September 2017
Relevant Location:	Liverpool
Type of case:	Misconduct
Panel members:	John Penhale (Chair, Lay member) Patience McNay (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Peter Jennings
Hearings Coordinator:	Emma Bland
Nursing and Midwifery Council:	Represented by Silas Lee, Case Presenter
Miss Sibanda:	Present and represented by Preacher Prince Muguza
Facts proved:	Charges 1, 2, 3 and 4 found proved by admission
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Suspension order for a period of 2 months with no review
Interim order:	No order

Decision and reasons on application for hearing to be held in private

At the outset of the hearing Mr Lee, on behalf of the Nursing and Midwifery Council (NMC), made a request that this case be held partly in private on the basis that proper exploration of your case involves reference [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Muguza, on your behalf, indicated that he supported the application to the extent that any reference to [PRIVATE] should be heard in private.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with matters relating [PRIVATE] as and when such issues are raised. It was satisfied that this course was justified by the need to protect your interests and that this outweighed any prejudice to the general principle of public hearings.

Details of charge

That you, a registered nurse:

1. On 26 April 2020;

    a. administered Pregabalin and morphine (controlled drugs) to Patient B when it had been prescribed for Patient A; ***[PROVED BY ADMISSION]***
    b. failed to report the error at charge 1.a.; ***[PROVED BY ADMISSION]***

c. administered said medication without another nurse present contrary to controlled drug standard procedure; ***[PROVED BY ADMISSION]***
d. told Colleague 1 that said medication was missing; ***[PROVED BY ADMISSION]***

2. Your conduct at charge 1.d. was dishonest in that you knew that said medication was not missing, but intended for Colleague 1 to believe that it was missing; ***[PROVED BY ADMISSION]***

3. On 27 April 2020, when asked by Colleague 1 if you had administered said medication to Patient B, denied that you had done this; ***[PROVED BY ADMISSION]***

4. Your conduct at charge 3 was dishonest in that you knew you had administered said medication to Patient B, and intended for Colleague 1 to believe that you had not; ***[PROVED BY ADMISSION]***

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

Decision and reasons on facts

The panel heard from Mr Muguza, that you made full admissions to charges 1(a) – (d), 2, 3 and 4.

The panel accepted the advice of the legal assessor.

The panel therefore finds charges 1(a) – (d), 2, 3 and 4 proved in their entirety, by way of your admissions.

NMC opening statement

Mr Lee informed the panel that the charges arose whilst you were employed as a registered nurse at Clatterbridge Hospital, during the night shift on 26 to 27 April 2020. You worked on an acute mental health ward which comprised 22 beds. You were working alongside one other nurse and three support workers, which was the normal staffing level for the ward.

You began working on medications alone during the shift in question. Mr Lee informed the hearing that a controlled-drug system is in place in all NHS hospitals which stipulates that two nurses must be present when handling controlled drugs to carry out supervised and documented count-up procedures. However, NHS policy does allow for a single nurse to carry out medication rounds not involving controlled drugs.

At approximately 9pm, the Staff Nurse, Colleague 1, observed you with the controlled drugs book out and you said words to the effect of 'the controlled drugs count does not tally with the controlled drugs available'. According to the controlled-drugs policy, you should not have been counting or administering drugs on your own. Colleague 1 noted that four tablets were missing:

- Two tablets of morphine (10mg);
- One tablet of pregabalin (50mg); and
- One tablet of pregabalin (25mg)

Colleague 1 noted that the four missing medications matched those prescribed to Patient A. Colleague 1 asked if you had administered the medication in question, and you replied that you had not and the medications appeared to be missing. Following this, searches for the missing medication were undertaken, including searching the ward bins. Mr Lee referred the panel's attention to Charge 2, which is admitted. Charge 2 states that you acted dishonestly, as you knew the medication was not missing but had been administered by you.

Later in the shift, Patient B woke up and spoke with Colleague 1 regarding the recent medication that you had administered to him. Patient B told Colleague 1 that he had a good period of sleep from the medication and he observed that it looked different in colour from his usual medication. Through speaking with Patient B, Colleague 1 noted that it appeared you had given Patient B the medication that was actually prescribed for Patient A.

Colleague 1 approached you and asked if you had given Patient B the wrong medication by mistake. You stated that you had not. Mr Lee referred the panel's attention to Charge 4 which is admitted. Charge 4 states that you acted dishonestly as you knew you had administered the medication to Patient B, but maintained that you had not. Colleague 1 subsequently told you that Patient B made the disclosure. Following this, you then admitted that you had, in fact, given the medication to Patient B.

Colleague 1 carried out observations on Patient B and was of the view that no actual harm materialised from this medication error. Nevertheless, Mr Lee submitted that there was evidence of a serious risk of harm being caused. In response to your medication error at the time, you stated that you were sorry and felt too scared to say what had actually happened.

You left your shift at 7am and did not stay for the handover. Colleague 1 remained to escalate the matter. The Ward Manager, Colleague 2, was informed and called you by telephone in the morning to follow up with you. Colleague 2 spoke to you briefly but you were very distressed and the call was therefore concluded. Colleague 1 then telephoned you at 5pm and spoke to you. You disclosed that [PRIVATE] and that may have been relevant to your medication error.

Fitness to practise

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

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

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

Submissions on misconduct

Mr Lee reminded the panel of the meaning of "*misconduct*", that it is some sort of act or omission which falls short of proper professional standards, taking into account the circumstances. He went on to address each of the charges.

Charge 1a relates to the medication error. He submitted that it was clear in the evidence before the panel, that you knew you had made a mistake. He further submitted that you failed to follow the proper policy in relation to the administration of controlled drugs. Mr Lee referred the panel's attention to a summary flowchart diagram which sets out the detailed steps for administering controlled drugs, including the requirement for a second nurse or health care worker to check the drug, its strength, quantity and the identity of the recipient patient. Mr Lee submitted that parts of the policy were not implemented by you

on the day in question. He noted that, had the policy been followed properly, it would have been unlikely that the mistake would have occurred. Mr Lee further noted that you should have checked the medication when Patient B raised the specific concern that he might be getting the wrong medication as the colours were different from his usual medication. Mr Lee submitted that the administration of the wrong medication to the wrong patient falls short of the standards expected of a nurse. He noted that nurses are under a duty to ensure that controlled drugs in particular, are correctly administered. Mr Lee submitted that your medication error had the potential to cause serious harm to patients.

Addressing Charges 1b and 1d, Mr Lee submitted that both charges amount to an attempt to cover up your medication error, and in doing so, Patient B went the entire night without medical attention following administration of the incorrect medication. Mr Lee submitted that your conduct at charges 1b and 1d was an intentional effort on your part to protect yourself from the personal consequences of your medication error at the expense of Patient B's health.

Addressing Charge 1c, relating to your administration of medication without another nurse present, Mr Lee reminded the panel of relevant parts of the controlled drug policy which require a second nurse or health care worker to administer controlled drugs. He noted that handling controlled drugs is an essential and fundamental part of a nurse's role and submitted that your conduct on the day fell well below the standard expected of a nurse.

Mr Lee addressed Charges 1d and 2, which both relate to your statement to Colleague 1 that the medication was missing. Mr Lee submitted that you had told a lie to cover up a mistake that occurred. He submitted that this was concerning as you knew another registered professional was actively conducting a search for medication that you said was missing, when you knew it was not. Mr Lee submitted that your dishonesty was to protect yourself at the expense of patient safety. He further submitted that dishonesty was a breach of the fundamental tenets of the nursing profession.

Mr Lee also addressed Charges 3 and 4, which relate to your denial that you had administered drugs to Patient B. He submitted that this was a further instance where you had lied about your actions, several hours after the administration of medication to Patient B. He submitted that both charges amount to serious misconduct.

Mr Lee submitted that several parts of the NMC Code were engaged by the circumstances of this case, in particular standards 14, 16, 18, 19, 20 and 20.2. He concluded by submitting that each of the charges and sub-charges amount to misconduct.

Mr Muguza's submissions in relation to misconduct are included below as part of his submissions on impairment.

Submissions on impairment

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

Mr Lee submitted that a finding of current impairment is necessary on grounds of both public protection and public interest.

Mr Lee submitted that your conduct and dishonesty fall short of a number of standards expected of a nurse, including the duty of candour. He noted that your repeated dishonesty raises serious concerns in relation to your attitude. He noted that had Patient B not subsequently disclosed the medication error, the mistake may never have been discovered, as it was your intention at the time to cover this up.

Mr Lee acknowledged your reflective piece, which shows some limited insight into the medication error and your stressors at the time. He noted that your reflective piece addresses the initial medication error. However, it does not address your subsequent dishonesty in detail, namely, what caused you to act dishonestly, what you can do differently in the future, and the risk your dishonesty posed to patient safety and the reputation of the profession. He submitted that you demonstrated a developing insight at this stage. He submitted that until you demonstrate a well-developed insight into the medication error and the instances of dishonesty that followed, there remains a risk of repetition. Mr Lee concluded that you have failed to show sufficient insight to allay concerns of repetition.

Mr Lee submitted that the public interest was engaged to a high degree by the circumstances of this case and invited the panel to mark the seriousness of this incident so as to declare and uphold proper professional standards.

Mr Lee also drew the panel's attention to two positive testimonials, which confirm that you have been working in a nursing role without any issues since being reinstated.
Mr Lee concluded that dishonesty may be more difficult to remediate and that the panel may wish to see stronger evidence of insight and strengthened practice before concluding that a finding of impairment is no longer necessary.

Mr Muguza stated that you deeply regret your actions during the night shift of 26 April 2020. He submitted that the medication error and your subsequent dishonest conduct arose as a result of your mental state. He further submitted that your dishonesty was not intentional. He noted that if you were in your "*normal senses*" during the shift, you would not have acted in the same way.

Mr Muguza noted the content of your reflective statement and submitted that your medication error and subsequent dishonesty had taken place because you were under "*stress*" and "*shock*" that was compounded by your personal mental state, which stemmed from [PRIVATE]. Taken together, these factors "*over whelmed*" (sic) your

"*judgment*" and led you to act in an "*unprofessional and unethical manner*". He informed the panel that you regret attending your shift that day when you were not in a normal state of mind, and further, deeply regret endangering a patient by administering the wrong drugs. Mr Muguza noted that there were also cultural practices within the ward, particularly during the night shift, where policy in relation to the administration of controlled drugs was not always followed.

Addressing your departure from the ward at the end of the shift, Mr Muguza stated that you were previously asked by Colleague 2 to adopt a different working pattern and you were also asked to go home. He stated that there may have been a communication error on the day in question.

Mr Muguza invited the panel to consider the remedial process you have undertaken in the twenty-four months that have elapsed since the incident. In particular, he referred to your reflective statement and noted that, prior to the incident, there were no concerns raised about your nursing practice. Since the incident, "*[you] have surpassed the 12 months period [you were] given by the trust in [your] reinstatement letter as a written warning without any incidents or* [PRIVATE]*".*

Mr Muguza noted that you have reflected upon the impact of your drug administration error and your dishonesty within your statement. You state that the incident *"has shaped and moulded [you] both mentally and physically to be a different Practising Nurse in the delivery of my duties henceforth*". Mr Muguza noted that you have taken steps to [PRIVATE]. This, in turn, has also had a positive impact on your nursing practice. Your reflective statement states that [PRIVATE] "*has helped me become one of the most competent Nurse in our ward where no short cuts and having to ask my immediate superior on matters of concern and …. paying attention to detail when carrying out my duties which my line Manager has outlined in her testimonial email*". Mr Muguza noted that you are now "*vigilant*" and "*cautious*" in carrying out your duties and you are also mindful of the reputation of the nursing profession, Cheshire and Wirral Partnership NHS Foundation Trust and the NMC.

Mr Muguza stated that you are now a different person. He noted from your reflective statement, that *"[your] colleagues are now being referred to adopt [your] integrity of service delivery by [your] line manager*". You are aware of your professional obligations and consult with superiors. You also [PRIVATE] prior to any shift to ensure that the incident that took place during the night shift of 26 April 2020 does not repeat itself. He invited the panel to consider the highly positive testimonials from your agency and in particular, your current line manager which attests to the high standard of your current nursing practice, personal qualities and professional behaviours.

Mr Lee noted that there was some suggestion that there was a widespread culture of the controlled drugs policy not being applied. He noted that this may be considered in relation to Charge 1, but was of limited relevance and application to the dishonesty charges. He invited the panel to approach this issue with caution as live evidence has not been heard on the extent to which the policy was not followed. There was also very limited information available on this issue from your interview at local level.

Decision and reasons on misconduct

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

The panel accepted the advice of the legal assessor which included reference to the principles established by a number of relevant judgments.

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

The panel was of the view that your actions amounted to a breach of the Code. Specifically:

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

To achieve this, you must:

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
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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…

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your medication error and subsequent repeated instances of dishonesty were very serious and fell below the standards expected of a nurse. The panel therefore determined that your actions amounted to misconduct.

The panel considered that there was a clearly defined policy on the handling and administration of controlled drugs which you had not followed. It also noted that you were subsequently dishonest on two occasions during the shift when you were asked about the controlled medication. Further, the panel was mindful that your actions placed both Patient A (who had not received their medication at all) and Patient B (who had received the wrong medication), at a risk of serious harm. The panel considered that it was fortunate that this risk had not materialised. Moreover, your continued dishonesty in the hours during your shift prevented appropriate monitoring of Patient B and implementation of any corrective actions stemming from your medication error. The medication error only came to light when Patient B indicated that there had been an issue with the medication he had

received. The panel noted that your initial medication error was compounded by your subsequent dishonesty during the remaining hours of the shift.

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

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant*. In 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… 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 bore in mind that the overarching objectives of the NMC are 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 proper professional standards for members of those professions.

With respect to your past conduct, the panel finds that limbs (a), (b), (c) and (d) of the Grant test are engaged. Patient B was placed at an unwarranted risk of harm as a result of your serious misconduct, which included a medication error and continued dishonesty during your shift. Your misconduct brings the nursing profession into disrepute and you breached the fundamental professional principles of honesty and trustworthiness and of putting the interests of patients first. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel considered whether your fitness to practise is currently impaired. In considering this issue, the panel considered the evidence before it. It further considered the steps you have taken to strengthen your practice, the risk of repetition and your development of insight.

The panel acknowledged the positive testimonial dated 5 September 2022, from your agency, which has employed you as a temporary Registered Mental Health Nurse since August 2017. The agency describes you as "*caring, hardworking and reliable*". You are described as a "*valued member of the team*" who is therefore booked by clients "*on a long-term basis*".

The panel also considered that you have since undertaken comprehensive training to remedy targeted areas of regulatory concern by way of completion of a full preceptorship programme. The panel noted the highly positive testimonial of your current Ward Manager dated 5 September 2022 who confirms that "*full preceptorship was completed along with medication competency framework. The Ward Manager and Band 6 Clinical Lead supervised medication competency. Ward manager signed off the competency with no concerns. Regular supervision was recorded and no issues were raised by any member of the team*".

Your current ward manager also describes your attitude and states that you are "*very thorough in [your] duties…and work well with staff and patient group"*. Moreover, she states that you are "*highly respected*". In describing your performance, she states that you "*work with great diligence and accuracy*". She further states that you "*ask questions if [you] are unsure and has no issues asking for assistance*".

The panel also noted that you have been working unrestricted as a registered nurse since the incident and no further regulatory concerns about your nursing practice have been raised. The panel was therefore not persuaded that there was a risk of repetition and in the panel's view, a finding of impairment on public protection grounds was not necessary.

The panel was of the view that your insight, as demonstrated by your written reflective piece, was promising and would benefit from further development. When considering your insight, the panel bore in mind that it can only decide matters based on evidence that it has heard and cannot speculate on matters for which no evidence has been heard.

However, the panel determined that a finding of impairment is required in the circumstances of this case to mark the seriousness of the misconduct. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired, but on public interest grounds alone.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of two months with no review. As a result of this order, the NMC register will show that your registration has been suspended.

Submissions on sanction

Mr Lee informed the panel that in the Notice of Hearing, dated 25 July 2022, the NMC had advised you that it would seek the imposition of a six-month suspension order with a review if the panel found your fitness to practise currently impaired.

Mr Lee confirmed that the NMC sanction bid remained the same, notwithstanding the panel's finding that there are no current public protection concerns in relation to your nursing practice. He submitted that a six-month suspension order with a review is the only sanction that properly marks the seriousness of the case.

Mr Lee referred the panel to the relevant NMC Guidance on sanctions, and in particular, guidance on dishonesty which states that "*the most serious kind of dishonesty is when a nurse…deliberately breaches the duty of candour when something goes wrong in someone's care*". Mr Lee submitted that this guidance is of particular relevance to the circumstances of this case.

Mr Lee outlined factors which made this case more serious: the deliberate breach of a professional duty; the vulnerability of the victim on an acute mental health ward; and the risk of harm to patients. He also submitted that there were factors which made this case less serious, namely: that this was a was a one-off incident arising from a single shift; and that the conduct did not appear to be pre-meditated.

Starting with the least restrictive form of sanction, Mr Lee submitted that neither a caution order nor a conditions of practice order would be sufficient to mark the seriousness of the misconduct in this case. In particular, it would not be possible to formulate conditions of practice that are workable and proportionate. He noted that conditions may be considered an insufficient sanction to uphold confidence in the profession given the nature of the panel's findings. He submitted that conditions are inappropriate to address dishonesty.

Mr Lee submitted that the dishonesty in this case was so serious that only temporary removal from the register would be sufficient as a form of sanction. He noted the findings of the panel and submitted that your insight would benefit from greater development. He submitted that you have not fully explained your dishonesty in detail and not offered a full reflection on the importance of trust in the nursing profession.

Addressing the issue of your dishonesty and wider insight, Mr Muguza reminded the panel that you had provided a written reflective piece which related to: the initial medication error; your dishonesty; [PRIVATE]; and [PRIVATE].

[PRIVATE]

Mr Muguza emphasised the comprehensive remedial process you had subsequently undertaken over a period of 24 months, which involved: completion of your preceptorship; completion of medication competency assessments; and regular supervision sessions. He drew the panel's attention to your highly positive testimonials.

Mr Muguza submitted that your misconduct was a single incident and a one-off error. He noted that no regulatory concerns were raised prior to your misconduct, and there has been no repetition of concerns since. He referred to the context and working practices of the ward at the time, and noted that older nurses did not follow the controlled drugs procedure. Mr Muguza noted that you were relatively new in this post and that your misconduct had taken place within this practice culture.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel accepted the advice of the legal assessor.

The panel took into account the following aggravating features:

- Your deliberate breach of the duty of candour on two occasions and the resultant risk of patient harm; and
- The vulnerable nature of Patient B who was on an acute mental health ward.

The panel also took into account the following mitigating features:

- That this was an isolated incident which took place during a single shift;
- [PRIVATE];
- The working practices of the ward at the time which may have contributed, in part, to your original medication error;
- The absence of any repetition of the regulatory concern since the misconduct and that you have worked without restriction for the past 24 months;
- The positive testimonials that attest to your comprehensive training, performance and conduct as a registered nurse since this incident.

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 action.

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

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

The panel is, however, of the view that there are no practical or workable conditions that could be formulated, given the nature of the findings in this case that relate to dishonesty. The misconduct identified in this case was not something that can readily be addressed through retraining. The panel was mindful that you have already remedied regulatory concerns in relation to medication administration.

Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case, nor mark the public interest concerns arising from the circumstances of this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. 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 harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

Balancing all of these considerations, the panel has concluded that a suspension order would be the appropriate and proportionate sanction. The panel was mindful of the gravity of the misconduct in this case. The panel considered that a suspension order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of two months was appropriate in this case to mark the seriousness of the misconduct. In accordance with Article 29 (8A)

of the Order, the panel has determined that a review of the substantive order is not necessary.

The panel noted that there were no longer any public protection concerns in relation to your practice and that you had demonstrated remediation of concerns surrounding medication administration through your substantial training and testimonials. The panel also noted that you had practised unrestricted for 24 months with no repetition of the regulatory concerns. The panel was satisfied that patients will not be at risk, directly or indirectly, and that there are no general concerns about your practice. It did not consider that there was any evidence of harmful deep-seated attitudinal problems.

The panel was also satisfied that you possess insight. While it bore in mind that your insight may be incomplete, it also bore in mind that the principal significance of insight is in its relevance to the risk of repetition. For the reasons the panel has already set out, it is not of the view that you are likely to repeat your misconduct. The panel determined that you are a competent nurse and it recognised the public interest in not losing the services of a clinically competent and skilled nurse. The panel is satisfied that an order for a period of two months, without a review, is the appropriate and proportionate order in this case.

The panel did go on to consider whether a striking-off order would be proportionate. The panel was satisfied that, in this case, the misconduct was not fundamentally incompatible with remaining on the register. Taking account of all the information before it, and of the mitigation provided, the panel concluded that a striking-off order would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

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

The panel has made the suspension order having found your fitness to practise currently impaired, but in the public interest alone. The panel determined that the order will satisfy

the public interest in this case and will maintain public confidence in the profession as well as the NMC as the regulator. Further, the order will declare and uphold proper professional standards. Accordingly, this suspension order will expire, without review, at the end of its term.

This will be confirmed to you in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order until the substantive sanction takes effect, 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 is in your own interest. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Lee. He invited the panel to make an interim suspension order for 18 months. He referred the panel to the relevant NMC Guidance which emphasised the panel's discretion in imposing an interim order. Mr Lee noted the absence of any public protection concerns in this case and invited the panel to consider whether it would be proportionate to direct an interim order during the 28-day appeal period.

Mr Muguza provided no further comment.

Decision and reasons on interim order

The panel was satisfied that an interim order is not necessary for the protection of the public. It has found that there are no current public protection concerns. It is similarly

satisfied that this is not a case where an order would be in your own interests. In the light of the reasons given for its substantive order, the panel is of the view that an interim conditions of practice order is neither necessary nor feasible.

The question for the panel therefore is whether, notwithstanding the absence of any public protection concerns, an order is otherwise in the public interest in order to maintain public confidence in the profession and its regulatory process. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order. As the panel has set out in its earlier determination, it made the substantive suspension order in order to mark the gravity of your misconduct and the seriousness with which the profession regards it. A restriction on your practice would not otherwise have been necessary: you have practised without incident for some two years since these events and, in directing that there is no need for a review, the panel was satisfied that neither public protection nor the public interest requires any further restriction in the future.

In the panel's judgement, a reasonable and well-informed member of the public who bore in mind and understood the reasons that the panel has given for its decisions on impairment and on the substantive sanction would not have his or her confidence in the profession and in the robustness of its regulatory process undermined by the panel's leaving the substantive order to take effect in the normal course. He or she would not regard an otherwise unnecessary interim order as required simply to maintain public confidence.

The panel therefore concluded that an interim order is not required in this case and that the statutory requirements for making such an order are not met. Further, in view of the impact that an interim order would have on you, seen in comparison with the substantive sanction, an interim order would not in the panel's view be proportionate.

Accordingly, the panel makes no interim order.

If no appeal is made, then the substantive suspension order will come into effect 28 days after you have been sent the decision of this hearing in writing.

That concludes this determination.