Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Friday, 2 February 2024

Virtual Hearing

Name of Registrant:	Dorothy Onwuteaka
NMC PIN	19K0631O
Part(s) of the register:	RN1, Registered Nurse - Adult (20 November 2019)
Relevant Location:	Bournemouth
Type of case:	Lack of competence
Panel members:	Nicola Dale (Chair, lay member) Jacqueline Metcalfe (Registrant member) Clare Taggart (Lay member)
Legal Assessor:	Richard Ferry-Swainson
Hearings Coordinator:	Jack Dickens
Nursing and Midwifery Council:	Represented by Mohsin Malik, Case Presenter
Mrs Onwuteaka:	Present and not represented at this hearing
Order being reviewed:	Suspension order (6 months)
Fitness to practise:	Impaired
Outcome:	**Suspension order (12 months) to come into effect on 12 March 2024 in accordance with Article 30 (1)**

Decision and reasons on review of the substantive order

The panel decided to confirm the current suspension order.

This order will come into effect at the end of 12 March 2024 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the second review of a substantive suspension order. This order was originally imposed for a period of six months by a Fitness to Practise Committee panel on 10 February 2023. The order was first reviewed on 28 July 2023 when the panel imposed a further six-month suspension order.

The current order is due to expire at the end of 12 March 2024.

The panel is reviewing the order pursuant to Article 30(1).

The charges found proved in their entirety by way of admission which resulted in the imposition of the substantive order were as follows:

'That you, a registered nurse, between November 2019 and April 2021, failed to demonstrate the standards of knowledge, skill and judgement required to practise without supervision as a Band 5 nurse in that you:

1. *On 20 November 2019 in respect of a patient with a NEWS score of 3:-*
    a. *Failed to recognise that the patient's blood pressure was not within normal parameters.*
    b. *Failed to carry out a further review of the patient or escalate the patient's NEWS score to a more senior nurse or doctor.*

2. *On 28 November 2019*
    a. *Were 15 minutes late for the shift;*
    b. *Fell asleep during the shift.*

3. *On 13 December 2019*
    a. *Were late for handover;*
    b. *Required prompting to check patient identification before administering medication on one or more occasions;*
    c. *Required prompting to check patient observations before administering medication on one or more occasions;*
    d. *Took one and a half hours to complete a drug round for 5 patients;*
    e. *Failed to communicate effectively with a patient to gauge their level of pain;*
    f. *Were unable to calculate the appropriate level of pain relief for a patient;*
    g. *Took 45 minutes to carry out pre-operative checks for one patient;*
    h. *Failed to carry out required observations for five patients by lunchtime;*
    i. *Failed to update the written handover sheet to an adequate standard for one or more patients.*

4. *On 24 October 2020 failed to complete the following records for one or more patients:-*
    a. *Nursing evaluation;*
    b. *Patient repositioning charts;*
    c. *Patient food charts;*
    d. *Mouthcare charts.*

5. *On 25 October 2020*
    a. *Did not know how to escalate a patient with a NEWS score of 7 to a doctor;*
    b. *Did not complete repositioning of patients and/or patient nursing evaluations in a timely manner;*
    c. *Were unable to complete a nursing evaluation without assistance from a colleague;*

d. Failed to handover to night staff that a patient had a NEWS score of 5.

6. On 2 November 2020

a. Failed to record a patient's observations;
b. Failed to complete the required admissions assessments and/or admissions documentation by the end of the shift;
c. Required prompting to update the handover sheet and/or to do a verbally recorded handover for the night staff;
d. Failed to record a patient's blood sugar result in a timely manner;
e. Attempted to give Aspirin and Clopidogrel to a patient without knowing their indications;
f. Required prompting to review a patient's blood sugar level before administering medication for diabetes;
g. Required prompting to review a patient's observations before administering hypertensive and/or diuretic medications on one or more occasions.
h. Failed to ensure that a patient received IV antibiotics when required;
i. Were unable to communicate clearly and/or effectively during a board round with the multi-disciplinary team;
j. Failed to remove a patient's catheter in a timely manner;
k. Failed to complete the admissions process and/or complete the required admissions documentation for a patient by the end of the shift;
l. Failed to complete neurovascular observations for a patient;
m. Failed to complete a written handover and/or verbal handover to an adequate standard.

7. On 12 November 2020

a. Failed to complete the drug round for four patients in a timely manner;

b. Attempted to incorrectly administer the following medication during the drug round:-

i. Paracetamol in tablet form;

ii. A 100mcg tablet of Fludrocortisone;

iii. 2.5 mls of Oramorph.

c. Failed to complete a patient's admission in a timely manner;

d. In respect of a patient with a blood oxygen saturation level of 80-84%:-

i. Failed to immediately escalate the patient's condition to your supervising nurse or a doctor;

ii. Failed to document your discussion with a doctor in the patient's notes;

iii. Failed to follow the doctor's instruction to administer oxygen to the patient or arrange for a colleague to do so.

8. On 15 November 2020

a. Failed to complete the administration of medication to one patient in a timely manner;

b. Required prompting to ascertain a patient's pain score;

c. Incorrectly stated to your supervising nurse that pro re nata medication should be administered to a patient instead of their regularly prescribed dose;

d. Required prompting to check a patient's observations before administering Amlodipine;

e. Attempted to administer Movicol when:-

i. It was not clinically indicated;

ii. You had not checked that the patient consented to its administration;

f. Were unable to accurately explain why a patient was prescribed Enoxaparin twice a day;

g. Failed to empty a patient's urometer between 7am and 12 noon;

h. Failed to record a patient's fluid intake and output on a fluid balance chart between 7am and 12 noon;

i. Required prompting to remove a theatre canvas from beneath a post- operative patient.

9. On 16 November 2020

a. Administered Mebeverine, Etololac and Quetiapine when you were unable to explain what their indications were;

b. Failed to record in a communication sheet that a post-operative patient needed to be prescribed intravenous antibiotics;

c. When you had removed a patient's catheter:-

i. Failed to record removal of the catheter in the patient's notes;

ii. Failed to update the patient's fluid balance chart or record whether the patient had passed urine after removal of the catheter.

10. On 20 December 2020

a. Had to be prompted to check the indication for medication before administering it on one or more occasions;

b. Failed to check whether Pro Re Nata medication could be administered on one or more occasions;

c. Failed to complete the drug round in a timely manner.

11. On 17 February 2021 during a mock non-intravenous medication administration assessment:-

a. Did not meet six of the criteria set out in the assessment form;

b. Administered medication without knowing its indication on one or more occasions;

c. Attempted to incorrectly administer a 2.5mg dose of Nebivolol;

d. Failed to complete the administration of medication to seven patients in a timely manner.

12. On 6 March 2021 during a formal non-intravenous medication administration assessment:-

a. Failed to complete a drug round in a timely manner;

b. Left the drug trolley unattended;

c. Attempted to incorrectly use water instead of saline for a nebuliser;

d. Failed to check if a "nil by mouth" patient had been administered their morning medication by the night staff.

13. On 17 March 2021

a. Gave a patient two 500mg paracetamol tablets when one tablet was the correct dose;

b. Took 25 minutes to administer medication to two patients.

14. On 5 April 2021 did not know how to perform a full set of neurological observations.

15. On 8 April 2021

a. Failed to carry out pressure area care for a patient between 9am and 1.30pm;

b. Failed to ensure that a patient was ready to be discharged at 1.30pm;

c. Failed to complete patient documentation including bedside notes and/or SKINN bundle (skin assessment) and/or falls prevention plans, for one or more patients

i. in a timely manner; and/or

ii. to an adequate standard.

d. Were unable to explain the difference between a total hip replacement and a hemiarthroplasty to your supervising nurse.

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

The previous panel, on 28 July 2023, found the following in respect of impairment:

‘The panel considered whether your fitness to practise remains impaired.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account your reflective piece. The panel was of the view that sufficient insight had not been developed and noted that the reflective piece has not been fully completed. It noted that only a single concern from an extensive and wide-ranging list of concerns about your practice was addressed in the reflective piece. The panel also heard that you have undertaken training; however, you have not presented the panel with any certificates, nor have you set out the context for the type of training you have completed.

The original panel determined that you were liable to repeat matters of the kind found proved. Today’s panel has not heard any new information which will reduce the risk of repetition of your mistakes. In light of this, this panel determined that there is a risk that you will repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that your fitness to practise remains impaired.’

The previous panel, on 28 July 2023, found the following in respect of sanction:

‘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.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your 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 your lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice order on your registration would be a sufficient and appropriate measure. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest. The panel was not able to formulate workable conditions of practice that would adequately address the concerns relating to your lack of competence.

The panel determined therefore that a suspension order is the appropriate sanction. It will protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a suspension order for the period of six months to provide you with an opportunity to strengthen your practice and to provide a reviewing panel with evidence of any training that you have completed. This will also enable you to develop, insight into your lack of competence. It considered this to be the most appropriate and proportionate sanction available.'

Decision and reasons on current impairment

This panel has considered carefully whether your Fitness to Practise remains impaired. Whilst there is no statutory definition of fitness to practise, the Nursing and Midwifery Council (NMC) has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a

comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it. It has taken account of the submissions made by Mr Malik, on behalf of the NMC, and by yourself.

Mr Malik submitted that a finding of impairment should be made on the grounds of public protection and in the public interest.

Mr Malik highlighted to the panel, that based on the evidence before the panel today, since the last review you have undertaken three hours and 45 minutes of continual professional development. He submitted that it is for the panel to decide whether this is enough to mitigate the risks identified.

Mr Malik referred to the reflective piece provided by you today. He submitted that this reflection does not demonstrate insight, however it is a matter for the panel to assess whether this reflection demonstrates sufficient insight.

Mr Malik submitted that nothing much has changed since the previous review and no information is before the panel today to indicate a reduction in risk and therefore the potential for harm remains. Accordingly, he invited the panel to continue the current suspension order for the protection of the public and in the public interest.

You said that the e-learning certificates you have provided to the panel show that you have learned from the incidents, and you have refreshed them recently, which is why they are dated within the previous few days. The panel asked whether the training certificates that were before it reflect the only training you have done. You said that you had done other training, such as document and record keeping, but considered the certificates you provided to be the most important and relevant. The panel asked whether the courses were assessed, to which you answered that there was no physical assessment, but you have to get the questions correct to progress through the course. You submitted that you need the suspension order to be lifted to enable you to put these skills into practise.

You said that since the incident you have reflected on what was wrong with what you did and what you would do differently and if you were able to return to practice you would have the confidence to ensure you do things correctly. You acknowledged that you had not reflected upon all the charges but thought that the charge you had reflected on was most applicable due to the similar nature of the other charges. The panel asked whether you had reflected upon the other charges, you said that you had but have not written a reflection on them. When the panel asked you about the reflection you provided today, you confirmed that the reflection was written on the 29 January 2024 but was a modified version of the previous reflection from July 2023, having gained assistance from a senior colleague who told you how to make the reflection better.

The panel asked you whether you were still undertaking the top-up BSc course, referred to in your reflection, you said that you were no longer able to pay the fees, so have had to withdraw from the course.

The panel asked whether you are employed and if so, what work you have been doing. You told the panel that you have be working in a non-nursing role at a care home, tending to clients including moving and handling duties, personal care, and providing medication, albeit under direct supervision. You told the panel that you have not obtained a testimonial from your employer as you are not working in a nursing role and the employer thought it would not assist the panel.

The panel asked about your nursing career. You said that you have been a nurse for more than 30 years. You said that you were a nurse on a medical surgical unit in Nigeria for 18 years and then worked as a midwife in the Caribbean for 12 years before coming to the UK.

The panel heard and accepted the advice of the legal assessor.

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether your fitness to practise remains impaired. The panel noted that the incidents concerned a series of wide-ranging failures of fundamental nursing skills over a sustained period of time. It considered that your reflection only addresses one of the incidents and was concerned by the lack of any reflection or insight into the other incidents, which included numerous clinical, medication, and record-keeping errors, among other essential nursing interventions. Your reflection, which was essentially the same as that submitted to the last reviewing panel, addressed one serious but narrow issue of the charges found proved and does not address the deficiencies in other areas of practice. This was despite the previous reviewing panel highlighting this and making it clear that the next reviewing panel would be assisted by an updated reflective piece demonstrating insight into each charge.

The panel considered the continual professional development that you have undertaken to strengthen your practice. It noted that since the last review on 28 July 2023, you have undertaken three hours and 20 minutes of continuing professional development undertaking three online courses, addressing a narrow scope of the failings. It noted that two of these courses were based on communication and this does not go towards evidencing how you have strengthened your practice in relation to all the charges.

The panel heard no new information today that indicated that the risk had reduced or that the concerns would not be repeated. Therefore, the panel concluded that you continue to be impaired on the ground of public protection as it has no confidence in your ability to practise safely at this time.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required as a member of the public would be concerned if you were allowed to practise at this time as the charges are wide ranging and relate to fundamental nursing skills.

For these reasons, the panel finds that your fitness to practise remains impaired.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and would not adequately mitigate the concerns. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your 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 your lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice order 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 bore in mind the seriousness of the facts found proved and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest. The panel was not able to formulate conditions of practice that would adequately address the concerns relating to your extensive lack of competence. In reaching this conclusion, the panel took into account all the support your employer at this time had put in place, but which did not appear to make a material difference to your level of competence.

The panel considered the imposition of a further period of suspension. It was of the view that a suspension order would allow you further time to fully reflect on all your failings. The panel concluded that a further 12-month suspension order would be the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice. The panel took into account the impact that such an order would have upon you, however the need to protect the public and the public interest outweighs your interests in this regard.

The panel did not go on to consider strike-off as it was not a sanction that was available to it at this time.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of date in accordance with Article 30(1).

Before the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Evidence of professional development, such as any updated relevant training you have undertaken covering the wide scope of your failings;
- An updated reflective piece which focuses on the entirety of the charges found proved and demonstrates insight to each charge;
- Testimonials or references from your current employer and/or colleagues about your conduct and performance (in a healthcare or non-healthcare role); and
- Your continued engagement with the NMC as well as attendance at any future hearings.

This will be confirmed to you in writing.

That concludes this determination.