Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Wednesday 14 February 2024 – Friday 16 February 2024
Monday 19 February 2024 – Thursday 22 February 2024
Wednesday 1 May 2024 – Friday 3 May 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Nyarayi Hwayire**
NMC PIN	07C0943E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (April 2007)
Relevant Location:	Buckinghamshire
Type of case:	Misconduct
Panel members:	Adrian Blomefield (Chair, Lay member) Rosalyn Mloyi (Registrant member) James Kellock (Lay member)
Legal Assessor:	Juliet Gibbon
Hearings Coordinator:	Charis Benefo (14 – 21 February 2024, 1 – 3 May 2024) Christine Iraguha (22 February 2024)
Nursing and Midwifery Council:	Represented by Kamran Khan, Case Presenter
Miss Hwayire:	Not present and unrepresented
Facts proved:	Charge 1, 2, 3a, 3b, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7 and 8
Facts not proved:	Charge 6c
Fitness to practise:	Impaired

Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

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

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Miss Hwayire's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Miss Hwayire

The panel next considered whether it should proceed in the absence of Miss Hwayire. It had regard to Rule 21 and heard the submissions of Mr Khan who invited the panel to continue in the absence of Miss Hwayire.

Mr Khan referred the panel to the email correspondence from Miss Hwayire dated 10 January 2024, 11 January 2024 and 22 January 2024 which indicated that she would be in [PRIVATE] during February 2024. In the email dated 22 January 2024, Miss Hwayire also

stated that she was '*not accepting the hearing*'. Mr Khan submitted that all of Miss Hwayire's emails to the NMC indicated that she would not be attending the hearing.

Mr Khan submitted that the NMC had explored the option of virtual attendance with Miss Hwayire and sought information about her travel arrangements, however she did not accept this and refused to provide information about her travel. Mr Khan submitted that none of Miss Hwayire's responses indicated a desire to attend the hearing.

Mr Khan submitted that the panel would have to undertake a balancing exercise as to whether to proceed in Miss Hwayire's absence or adjourn to secure her attendance on a different date. He submitted that Miss Hwayire was given ample notice of this hearing and had not asked for an adjournment. Mr Khan submitted that her reasons for non-attendance would not satisfactorily prompt a panel to consider an adjournment. He submitted that it was also counterintuitive that Miss Hwayire could not attend the hearing due to [PRIVATE].

Mr Khan submitted that Miss Hwayire was facing eight charges, all of which related to significant regulatory concerns. He submitted that Miss Hwayire knew the process as there had been a number of interim order hearings, and that she chose not to attend the last interim order review hearing in December 2023. Mr Khan submitted that Miss Hwayire had effectively made another active choice not to attend this hearing. He therefore submitted that there was no good reason to adjourn this hearing in the absence of any express application to adjourn.

Mr Khan submitted that even if the panel was minded to adjourn the hearing today, based on the information before it, there was no indication that Miss Hwayire would attend the next hearing.

The panel accepted the advice of the legal assessor.

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

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

- No application for an adjournment has been made by Miss Hwayire;
- Miss Hwayire initially informed the NMC in an email dated 10 January 2024 that she would be abroad in February 2024, during the scheduled dates of this hearing;
- The NMC provided Miss Hwayire with the alternative option of joining the hearing via video link. However, in her email dated 22 January 2024, Miss Hwayire stated '*At the moment I can't commit to nmc virtual hearings as I am [PRIVATE]*;
- Miss Hwayire did not respond to the NMC's suggestion of attending the hearing from abroad via video link, but maintained that she would not be attending the hearing;
- The panel was not made aware of any alternative options that the NMC had explored with Miss Hwayire to attend. However, the panel was satisfied that this was outweighed by the other factors;
- There is no reason to suppose that adjourning would secure Miss Hwayire's attendance at some future date;
- Two witnesses are due to attend to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2020 and 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Hwayire in proceeding in her absence. The evidence upon which the NMC relies will have been sent to Miss Hwayire at her registered email address and she has responded to the allegations by providing documents, including a reflective account. However, Miss Hwayire will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give oral evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Miss Hwayire's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide oral evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Khan to amend the wording of charges 1 and 3b.

The proposed amendment to charge 1 was to rectify the nature of Miss Hwayire's alleged error in respect of the residents at charge 1, and to correct the number of residents affected by the alleged error.

The proposed amendment to charge 3b was to correct a typographical error in the date of the alleged failure to administer medication to a resident.

It was submitted by Mr Khan that the proposed amendments would provide clarity, would more accurately reflect the evidence, and would not cause injustice to Miss Hwayire.

"That you, a registered nurse:

1) On 1 July 2020 ~~administered the incorrect medication to 2 residents~~ **entered incorrect medication to a resident's MAR chart with the medication of another resident** who shared the same initials.
   ...
3) Failed to administer Apixaban to a resident on:
   b) ~~29~~ **19** July 2020"

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The evidence before the panel in respect of charge 1 related to the recording of medication on a resident's MAR chart, rather than the administration of medication. The panel decided that it was necessary for the wording of charge 1 to reflect this evidence. The panel noted that the proposed amendment to charge 3b was to correct a typographical error.

The panel was of the view that such amendments were in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Hwayire and no injustice would be caused to either party by the proposed amendments being allowed. However the panel considered that it would be better if charge 1 read:

"That you, a registered nurse:

1) On 1 July 2020 incorrectly wrote medication on a resident's MAR chart reflecting the medication of another resident who shared the same initials."

Mr Khan did not object to the panel's proposed wording.

The panel considered that it was appropriate to make the amendments to ensure clarity and accuracy.

Details of charge [as amended]

That you, a registered nurse:

1) On 1 July 2020 incorrectly wrote medication on a resident's MAR chart reflecting the medication of another resident who shared the same initials.

2) On 5 July 2020 failed to administer Alendronic acid to a resident.

3) Failed to administer Apixaban to a resident on:
   a) 18 July 2020
   b) 19 July 2020

4) Administered an incorrect dose of Fludrocortisone to a resident on:
   a) 23 July 2020
   b) 24 July 2020
   c) 25 July 2020

5) On 27 July 2020:
   a) Failed to administer Apixaban to a resident.
   b) Failed to sign for the administration of Insulin to a resident.

6) On 28 July 2020 behaved in an unprofessional manner towards Colleague A in that you:
   a) Shouted aggressively.
   b) Called Colleague A 'incompetent'
   c) Refused to allow Colleague A to undertake a competency assessment with you.

7) On an unknown date on or before 30 July 2020 failed to maintain patient confidentiality in that you took and stored photographic images of patient medication administration chart(s) on your personal mobile telephone.

8) On 24 November 2022 sent an inappropriate email to the NMC containing graphical representations or 'emoji's' of faeces.

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

Decision and reasons on application to admit Witness 3's written statement as hearsay evidence

The panel heard an application made by Mr Khan under Rule 31 to allow the written statement of Witness 3 into evidence. Witness 3 was not present at this hearing and, whilst the NMC had made efforts to ensure that this witness was present, the NMC was unable to secure her attendance.

Mr Khan said that numerous attempts have been made to call the witness who queried why she must attend as she no longer works at [PRIVATE] (the Home) and was on holiday when the incidents that led to the allegations occurred. Further attempts were made by the NMC to secure Witness 3's attendance while the hearing was underway. He stated that the NMC has done all it can to secure Witness 3's attendance. Witness 3's evidence does not necessarily go to proving the charges but provides context as to when

Miss Hwayire initially re-joined the Home. Witness 3 states that Miss Hwayire was perfectly competent and signed her first monthly probationary supervision record. The only concern was that Miss Hwayire had only completed three eLearning training modules at that stage and she needed to ensure that all training was up to date by 15 July 2020, which is the month when seven out of the eight allegations occurred. Mr Khan submitted that taken at its highest, the document provides some background and context and has been endorsed by Miss Hwayire as she had signed the probation meeting notes.

Mr Khan referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) which sets out the factors to be considered when deciding whether or not to admit hearsay evidence. He submitted that Witness 3's statement is not the sole and decisive evidence that supports any of the charges. The nature and extent of the evidence cannot be challenged in Witness 3's absence. He said that the written statement does not add much but he submitted that the supervision note is a key document. He invited the panel to consider that the document is agreed, as it is signed by Miss Hwayire and there is no suggestion that Witness 3 had a reason to fabricate the information in her written statement.

Mr Khan addressed the panel on the seriousness of the charges and impact of adverse findings and submitted that the evidence does not go specifically to the charges but provides background to Miss Hwayire's character.

In the preparation of this hearing, the NMC had indicated to Miss Hwayire in the Case Management Form (CMF), that it was the NMC's intention to read out Witness 3's statement. Despite having knowledge of the nature of the evidence to be given by Witness 3, Miss Hwayire did not respond, nor did she engage with the NMC. Mr Khan invited the panel to accept Witness 3's evidence as hearsay evidence and said that Miss Hwayire agrees with the content.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far

as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the declaration, '*This statement is true to the best of my information, knowledge and belief' and signed by her. I confirm that I am not willing to attend a hearing and give evidence before a Committee of the NMC.*' It observed that Witness 3's evidence is not the sole and decisive evidence in this case and does not address any of the charges but provides context. The panel appreciated that Miss Hwayire cannot challenge this evidence due to her non-attendance, but the CMF sent to her indicated that Witness 3's evidence was to be read out and she had made no objection. It considered the numerous attempts made by the NMC to contact Witness 3 including the morning of 21 February 2024, when Witness 3 in an email stated that she was not sure why she was required to attend as she was not involved in the alleged incidents and had been on holiday at the time.

The panel observed that there was no unfairness to Miss Hwayire in admitting Witness 3's evidence and noted that in fact the probation report was broadly in favour of her. The panel accepted into evidence the written statement of Witness 3 and decided it would give what it deemed appropriate weight once it had heard and evaluated all the evidence before it.

Background

The NMC received a referral in respect of Miss Hwayire on 12 August 2020. Miss Hwayire first entered onto the NMC's register on 23 April 2007.

The allegations in this case arose whilst Miss Hwayire was employed by Hartford Care Ltd as a Night Nurse. At the time of the allegations, Miss Hwayire was working at the Home. Miss Hwayire started working at the Home in May or June 2020.

Whilst Miss Hwayire was working her probation period at the Home, the following concerns were raised about her practice:

- failure to administer medication safely;
- failure to maintain patient privacy and confidentiality;
- failure to keep clear and accurate records; and
- unprofessional behaviour towards colleagues.

It is alleged that between 1 July 2020 and 27 July 2020, Miss Hwayire made a number of medication administration and record keeping errors. This included allegedly recording a resident's medication on another resident's MAR chart, failing to administer medication to residents, administering the incorrect dose of medication to a resident, and failing to sign for the administration of medication to a resident.

On 28 July 2020, in a meeting with Witness 1/Colleague A (the Deputy Manager of the Home) about the alleged medication errors, Miss Hwayire allegedly shouted aggressively at Colleague A, called them "*incompetent*" and refused to allow them to undertake a competency assessment with her.

A probation meeting was held between Miss Hwayire and the Regional Manager on 30 July 2020, where she allegedly stated that she had taken pictures of patient medication administration (MAR) charts on her personal mobile telephone. It is alleged that in doing so, Miss Hwayire failed to maintain patient confidentiality.

Miss Hwayire was dismissed from her role on 30 July 2020 following the probation meeting.

It is further alleged that on 24 November 2022, Miss Hwayire sent an inappropriate email to the NMC containing graphical representations or ‘emojis’ of faeces.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Khan on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Miss Hwayire.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1/Colleague A: Deputy Manager of the Home at the time of the allegations;

- Witness 2: Regional Manager at Hartford Care Ltd at the time of the allegations.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC, including the registrant response bundle (this had been compiled by the NMC from the material supplied by Miss Hwayire during the investigation).

In the absence of any formal admissions, the panel took it that Miss Hwayire denied the charges. The panel then considered each of the disputed charges and made the following findings.

The panel was not provided with any resident or staff records in respect of any of the incidents other than the MAR chart provided in respect of charge 1. Although the panel did request these documents, it was informed that they had been searched for and were not available. Therefore, the panel had to rely on other evidence it had before it.

Charge 1

That you, a registered nurse:

1) On 1 July 2020 incorrectly wrote medication on a resident's MAR chart reflecting the medication of another resident who shared the same initials.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's evidence, the MAR chart, a letter sent to Miss Hwayire from the Home dated 21 July 2020 and the transcript of the interim order hearing on 27 August 2020.

Witness 1 in her statement dated 23 November 2023, stated that '*There had also been an incident where a MAR chart had been completed with medication for the wrong patient'.* In her oral evidence she confirmed that *"some medications for one resident were written on another residents MAR chart".* When questioned by the panel, Witness 1 said, *"there were two medications, one was Senna and the other was eyedrops."* The panel observed that this correlates with the entries on the MAR chart. The MAR chart shows '*Senna tablets*' and '*Carmellose eye drops*' (these were on the left column of the chart) entered by Miss Hwayire.

The panel considered the letter sent to Miss Hwayire from the Home on 21 July 2020, which stated: '*As you are aware, the areas of discussion were; medication related incidents whereby you transcribed medication of a deceased resident in to another residents MAR chart. The reason you gave for this action was that [Colleague B] did not countersign the entry and that she took the medications and asked you to make the entry on the MAR sheet. It is your responsibility to ensure that you make accurate entries into the MAR sheet to minimize the risk of medication errors that may arise from inaccurate entries*.'

The panel took account of the transcript of the interim order hearing on 27 August 2020. Miss Hwayire's representative seemed to accept the mistake on her behalf having taken instructions from Miss Hwayire before addressing the panel, stating, '*you were informed by the NMC's Case Presenter that medicine which was meant for ... was given to [patient] on 1st July. In fact it was medication written on the wrong MAR chart. There was no medication error, but the medication was written into the wrong MAR chart.'*

The panel observed that charge 1 is dated 1 July 2020, but the entries on the MAR chart are dated 30 June 2020. The panel accepted that it was an overnight shift and that the error was discovered on 1 July 2020.

In view of the evidence before it, the panel was satisfied on the balance of probabilities, that on 1 July 2020 Miss Hwayire incorrectly wrote medication on a resident's MAR chart reflecting the medication of another resident who shared the same initials. It therefore found this charge proved.

Charge 2

That you, a registered nurse:

2) On 5 July 2020 failed to administer Alendronic acid to a resident.

This charge is found proved.

In reaching this decision, the panel took into account the registrant response bundle, the notes of probationary meeting on 30 July 2020, the notes of the investigation hearing on 7 July 2020, Witness 1 and Witness 2's evidence and the transcript of the interim order hearing on 27 August 2020.

In her handwritten response to the concerns document, Miss Hwayire effectively admitted the charge, she stated '*5th July I admit missing administering Alendronic acid early morning as I worked night shift. I was in charge of all the residents in the Nursing home.'*

In the probationary meeting on 30 July 2020, Miss Hwayire's did not disagree with Witness 2 when this incident was put to her. She responded in what Witness 2 considered to be in the affirmative by stating *'Mhm'.* Miss Hwayire provided a firm denial in relation to other allegations that she did not agree with, but did not respond with a denial when the failure to administer Alendronic acid was put to her. When Witness 2 was asked what her understanding of this response was, she said that she was very clear that she understood that to be Miss Hwayire accepting that she had not administered the medication.

The panel took into account the notes of the investigation hearing on 7 July 2020 which stated:

> '*[Witness 1]: Ok. So, first of all, the allegations about medication issues have been brought to my attention, on the 5th July 2020, Alendronic Acid hasn't been administered for Patient B'*
>
> *[Miss Hwayire]: For Patient B on the 5th*
>
> *[Witness 1]: Yes this was 5th, you worked on the 4th of July which was a Saturday night so Sunday morning you meant to administer Alendronic Acid*
> *...*

[Witness 1]: Yes and this hasn't been administered

[Miss Hwayire]: Ok. So that one if it isn't administered, I admit is my fault and I forget'.

Witness 1 in her oral evidence said that when she checked the MAR chart and the stock balance, both indicated that the medication had not been administered.

The transcript of the interim order hearing on 27 August 2020 records Miss Hwayire's representative accepting the error on her behalf. The representative stated, *'… and she accepts that she forgot to administer the alendronic acid …*'

On the evidence before it, the panel was satisfied that there was sufficient evidence to prove on the balance of probabilities that on 5 July 2020, Miss Hwayire failed to administer Alendronic acid to a resident. The panel therefore finds this charge proved.

Charge 3

That you, a registered nurse:

3) Failed to administer Apixaban to a resident on:
    a) 18 July 2020
    b) 19 July 2020

This charge is found proved.

In reaching this decision, the panel took into account the registrant response bundle, the transcript of the interim order hearing on 27 August 2020, the notes of probationary meeting on 30 July 2020 and Witness 2's evidence.

In Miss Hwayire's account in the handwritten responses to concerns document, she stated that '*Apixaban was missed because it wasn't prescribed on the MARS sheets*'. Further, in her reflective account form dated 14 April 2021 she stated '*Apixaban was missed because it was only entered on MARS chart OD and on the box twice a day.'*

The transcript of the interim order hearing on 27 August 2020 stated that '*… and she accepts that she forgot to administer the Alendronic acid and also the Apixaban'.*

The notes of the probationary meeting on 30 July 2020 indicated that when Miss Hwayire was asked by Witness 2, she did not disagree with the allegations put to her. The panel observed that Miss Hwayire provided a firm denial in relation to other allegations that she did not agree with; but did not deny this allegation. When Witness 2 was asked what her understanding was of Miss Hwayire saying '*Mhm*' when this failing was put to her, she was clear in her response that she understood it to be Miss Hwayire accepting that she had not administered the medication.

The panel was satisfied on the evidence before it, that Miss Hwayire had not administered Apixaban to a resident on 18 and 19 July 2020. It therefore found this charge proved on the balance of probabilities.

Charge 4

That you, a registered nurse:

4) Administered an incorrect dose of Fludrocortisone to a resident on:
    a) 23 July 2020
    b) 24 July 2020
    c) 25 July 2020

This charge is found proved.

In reaching this decision, the panel took into account the notes of probationary meeting on 30 July 2020, the registrant response bundle, the email from Witness 1 to Witness 2 dated 28 July 2020, Witness 2's evidence, and the transcript of the interim order hearing on 27 August 2020.

Miss Hwayire in the notes of the probationary meeting on 30 July 2020 accepted that she had administered two incorrect doses to the resident. She also stated that the days on which she had administered the incorrect dose were not the only dates that the resident had been given the incorrect dose. This was acknowledged by Witness 2 in her statement as well as when questioned by the panel. Witness 2 also confirmed that the other incidents were addressed by the Home in respect of the other staff members involved on the other dates.

Miss Hwayire in the handwritten responses to concerns document denied the allegations stating that '*Fludrocortisone I am the one who discovered that other nurse were giving wrong dose* [sic]'. In addition, Miss Hwayire in her reflective account form dated 14 April 2021 stated that '*Fludrocortisone was given 0.5mg instead of 1.5 and I was the one discovered it after other nurses were administering* [sic]'.

The panel considered the email from Witness 1 to Witness 2 dated 28 July 2020 which stated '*… the senior nurse has approached me and she informed that we have a medication error, she said that Nyarayi told her that for … who has prescribed Fludrocortisone 100 mcg tablets, one and half to be administered once a day, and that for 6 days she had administered only one tablet, I have said to … to bring the Marr [sic] charts to have a look as well the medication box, after looking at Marr [sic] charts I have seen that this medication error has happened, after doing all the reports in the morning I have raised a Safeguarding for the medication error.*'

Witness 2 in her oral evidence said that before she started the interview, she had the MAR charts that Miss Hwayire had signed on those dates because the concerns had been raised by the deputy manager. Miss Hwayire had signed indicating that 1.5 tablets had

been administered. Witness 2 indicated that not only did she see the charts, but she went through the charts with Miss Hwayire on the day of the interview. She was able to identify that Miss Hwayire had administered the medication on those three dates because of her signatures on other MAR chart entries. In her evidence, Witness 2 stated that she carried out a drug count and was able to identify that it was Miss Hwayire who had administered the wrong dose on the days charged. The panel found Witness 2's evidence compelling.

The panel noted that Miss Hwayire had admitted to administering the incorrect dose on two dates in the probationary meeting of 30 July 2020, however, the panel took into account Witness 2's evidence that she had seen the resident's MAR chart and had gone through the records with Miss Hwayire which revealed that she was the nurse signing the MAR chart on all three of the dates charged.

Miss Hwayire's representative stated in the transcript of the interim order hearing on 27 August 2020 that '*You will be aware from the way the document is set out that she was challenged with four occasions on which the wrong medication was given, when the resident should have had 1.5 tablets and was given one tablet. The papers do not contain the issue that the Registrant was not the only person involved in that, and her position today before you is that two of those were hers. [sic]*'

The panel was satisfied that it had enough evidence to support this charge. It therefore found this entire charge proved on the balance of probabilities.

Charge 5a

That you, a registered nurse:

5) On 27 July 2020:
    a) Failed to administer Apixaban to a resident.

This sub charge is found proved.

In reaching this decision, the panel took into account the notes of probationary meeting on 30 July 2020, the registrant response bundle and Witness 2's evidence.

The panel considered the notes of the probationary meeting on 30 July 2020 that took place three days after the alleged incident. Miss Hwayire initially said that the resident refused the medication and she had documented this on the MAR chart. She also stated that she had discarded the medication she had dispensed and recorded this in the '*blue and black book*'. Witness 2 paused the interview and checked the records relating to this medication but found that neither the administration of the medication had been signed for on the relevant MAR chart, nor had the destruction of the medication been recorded. Witness 2 resumed the interview and challenged Miss Hwayire extensively on this and the fact that the medication count indicated that the drug had not been administered. In her oral evidence Witness 2 stated that following the meeting, she was of the view that the medication had not been administered by Miss Hwayire.

Miss Hwayire in the handwritten responses to concerns document stated '*Apixaban was missed because it wasn't prescribed on the MARS sheets*'. Miss Hwayire did not state whether that referred to 18/19 July 2020 (charge 3) or 27 July 2020. The panel interpreted her response as indicating that Apixaban was missed on all three dates, and it was satisfied by the evidence of Witness 2 that Miss Hwayire had failed to administer Apixaban to a resident on 27 July 2020.

On the evidence before it, the panel was satisfied on the balance of probabilities, that on 27 July 2020, Miss Hwayire had failed to administer Apixaban to a resident. It found this sub-charge proved.

Charge 5b

That you, a registered nurse:

5) On 27 July 2020:
    b) Failed to sign for the administration of Insulin to a resident.

This sub charge is found proved.

In reaching this decision, the panel took into account the notes of probationary meeting on 30 July 2020, the registrant response bundle and the transcript of the interim order hearing on 27 August 2020.

The panel noted Miss Hwayire's statement dated 21 September 2020 in which she stated '*Then on one occasion I forgot to sign the medication I gave insulin because I was called for an emergency. That was my last shift at [PRIVATE] nursing home.'* The panel noted that Miss Hwayire wrote this two months after the incident.

During the probationary meeting on 30 July 2020, Witness 2 and Miss Hwayire discussed the shift of 27 July 2020 and the notes state:

> '[*Witness 2]: Okay you also haven't signed for insulin on the Sunday.*
>
> *[Miss Hwayire]: Yes I forgot to sign the morning, no it is not, if it is the same day, yes in the morning I don't forget insulin, never, I don't forget it.'*

In the transcript of the interim order hearing on 27 August 2020, Miss Hwayire's representative stated that '*The insulin issues were examples of being called away. If there are insufficient nurses, on her analysis, to cover the medical needs of the residents, then these matters are going to happen.'*

On the evidence before it, including Miss Hwayire's admissions that she failed to sign for the administration of the insulin, the panel was satisfied on the balance of probabilities that this sub-charge is proved.

Charges 6a and 6b

That you, a registered nurse:

6) On 28 July 2020 behaved in an unprofessional manner towards Colleague A in that you:
   a) Shouted aggressively.
   b) Called Colleague A 'incompetent'

These sub-charges are found proved.

In reaching this decision, the panel took into account Witness 1's evidence, the email from Witness 1 to Witness 2 dated 28 July 2020 and the registrant response bundle.

Witness 1 is referred to as Colleague A in this charge.

Witness 1 in her written statement dated 23 November 2023 stated '*I explained to Nyarayi that the competency assessment was normal procedure following medication errors. Nyarayi immediately began to shout at me and became very aggressive and told me that I was incompetent and that she would only have a competency assessment done by …, the Home Manager. Nyarayi went on to say that she felt that this was harassment and that she was going to write a statement and send it to Head Office.'*

The panel considered the email from Witness 1 to Witness 2 dated 28 July 2020, which stated that '*she asked me what is the competency assessment for, and replayed [sic] to her that this is being done as a normal procedure following some many medications error, she started to shout and be [sic] aggressive that she will not have the competency assessment done even by me as I am incompetent as I have done medication error*'

The panel was presented with nothing from Miss Hwayire to refute or explicitly deny charges 6a and 6b. It did note, however, that she stated in an email to the NMC dated 17 January 2021 that:

> '*As well I would also want to express my disappointment with another issue of me not respecting manager. At [PRIVATE] Hartford care the nursing home I was working nights and management start work at 10. 00. Well if it is there deputy manager [Witness 1] she has to reflect the way she was speaking to me in front of carers during handover.*'

The panel was of the view that shouting aggressively at a colleague who was the deputy manager and then calling them incompetent was unprofessional behaviour. It noted that the deputy manager was senior to Miss Hwayire. Miss Hwayire should have addressed her displeasure in another manner that was more acceptable and professional.

The panel was satisfied that there was sufficient evidence to support these sub-charges and found them proved on the balance of probabilities.

Charges 6c

That you, a registered nurse:

6) On 28 July 2020 behaved in an unprofessional manner towards Colleague A in that you:
   c) Refused to allow Colleague A to undertake a competency assessment with you.

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's evidence, the transcript of the interim order hearing on 27 August 2020 and the email from Witness 1 to Witness 2 dated 28 July 2020.

Witness 1 (Colleague A) in her written statement dated 23 November 2023 stated that Miss Hwayire had said that she would only have a competency assessment done by the Home Manager. Miss Hwayire's representative in the transcript of the interim order hearing on 27 August 2020, stated '*The Manager was away, the Regional Manager was not available, and in the end [Witness 1] undertook that drug supervision. That actually took place on 27th July and Ms Hwayire completed the form and that assessment was successful.*' When Witness 1 was asked specifically during her oral evidence about this claim, she could not recall whether she had done the assessment or not due to the passage of time.

The panel noted that it was clear from Witness 1's account that Miss Hwayire initially refused to have the competency assessment done by her but then went on to write in the email to Witness 2, '*We come back [sic] to the competency assessment and she said that [Colleague C] was the one who did her competency assessment first and should be a fresh pair of eyes who should do it this time and ask me to do it, I have replayed [sic] that she just said that I am incompetent and how should I competency assess her, she replayed [sic] that we should leave this on the side.*'

The panel noted that the initial refusal by Miss Hwayire may be considered unprofessional. However, it observed that Witness 1 subsequently indicated that Miss Hwayire asked her to undertake the competency assessment with her.

The panel was of the view that the evidence before it was conflicting and there was an assertion that a competency assessment had taken place on 27 July 2020. However it was clear that on 28 July 2020, while Miss Hwayire initially refused to have a competency assessment with Witness 1, Miss Hwayire invited her to conduct such an assessment a short time after this.

In all the circumstances, the panel was not satisfied that it had before it clear evidence to show that Miss Hwayire refused to undertake a competency assessment with Witness 1. It therefore found this sub-charge not proved.

Charge 7

That you, a registered nurse:

7) On an unknown date on or before 30 July 2020 failed to maintain patient confidentiality in that you took and stored photographic images of patient medication administration chart(s) on your personal mobile telephone.

This charge is found proved.

In reaching this decision, the panel took into account the registrant response bundle, the notes of probationary meeting on 30 July 2020, the transcript of the interim order hearing on 27 August 2020 and Witness 2's evidence.

Miss Hwayire in her handwritten responses to the concerns document provided some detail and background to this incident. Further in her email to the NMC dated 21 June 2021, she accepted taking the picture of the '*signature space on the MARS chart*' but not photographic images of '*patients medical notes*'.

The notes of probationary meeting dated 30 July 2020 stated:

> '*[Miss Hwayire]: Yes I have... pictures of everything, of the ones who have done everything wrong, I have that.*
> *...*
> *From the MAR chart is good because the medication...*

[Witness 2]: Okay I'm just going to let you know while we're still recording this conversation, if you've chosen to take pictures on your personal phone and you intend to leave with that tonight, I will be safeguarding that immediately, because under GDPR rules and Data Protection, and consent issues, you do not have permission, you have not sought permission from our residents to take copies of their documents. So it's in your best interest if you have taken photos of MAR charts...

[Miss Hwayire]: No if I feel that I'm not being treated fairly, I need evidence.

[Witness 2]: No.

[Miss Hwayire]: Yes, I do.

[Witness 2] No, you record that...

[Miss Hwayire]: I've got every right to have it, I have every right to have it, yes I do.'

The panel noted that Miss Hwayire had already taken the pictures at that stage and when challenged about General Data Protection Regulation (GDPR) she did not say that she had only taken pictures of the signatures.

In the transcript of the interim order hearing on 27 August 2020, Miss Hwayire's representative explained that Miss Hwayire's sole purpose for taking the images was to send them to the Royal College of Nursing (RCN), stating, '*Can I be absolutely clear on behalf of the Registrant that the sole purpose for her taking images was to send them to the RCN because she felt unsupported and sought the support of her union.*' The panel noted that in the interim order representations, no mention was made of the images being limited to the '*signature space on the MARS chart*'. In fact, it was stressed that the RCN had escalated the matter within itself to the engineers, '*the RCN continues to work on solutions for its permanent deletion.*' It was clear to the panel that these were sent by Miss

Hwayire to the RCN, and it was considered serious enough to escalate to engineers to permanently delete the photographs. The panel determined that the RCN was unlikely to have taken such steps if there had been no GDPR breach.

The panel observed that it had not been provided with any photographic images and Witness 2 confirmed that she had not seen them either. In response to panel questions, Witness 2 confirmed that when she and Miss Hwayire were looking through the MAR charts in connection with charge 4, Miss Hwayire had attempted to take photographs of those MAR charts.

The panel was of the view that the evidence suggested that it was more likely than not that Miss Hwayire took photographs of residents' MAR charts and stored them on her personal mobile telephone. It considered that it was inherently implausible that the photographs were restricted to the '*signature space*' on the MAR charts as that would not have assisted Miss Hwayire in establishing that other nurses had made mistakes.

Whilst, the panel was not provided with copies of these photographic images, it was satisfied that this charge is proved on the balance of probabilities.

Charge 8

That you, a registered nurse:

8) On 24 November 2022 sent an inappropriate email to the NMC containing graphical representations or 'emoji's' of faeces.

This charge is found proved.

In reaching this decision, the panel took into account the emails from Miss Hwayire to the NMC dated 24 November 2020. The panel observed that there are 'emojis' which it recognised as representing faeces. It was of the view that the 'emojis' were an

inappropriate response to her regulator. The panel also determined that with two years having passed since Miss Hwayire was dismissed from the Home, sending such images could not be considered a response given in the heat of the moment. Miss Hwayire has not provided any comment on this charge. This charge is found proved.

The hearing was adjourned by the panel on 21 February 2024 due to lack of time, following its deliberations on the facts.

The hearing resumed on 1 May 2024.

Decision and reasons on service of Notice of Resuming Hearing

The panel was informed at the start of this hearing that Miss Hwayire was not in attendance and that the Notice of Resuming Hearing letter had been sent to Miss Hwayire's registered email address by secure email on 7 March 2024.

Mr Khan referred the panel to the email response from Miss Hwayire dated 16 April 2024 indicating that she would not be attending the resuming hearing as she is '*busy*'.

Mr Khan submitted that the NMC had complied with the Rules.

The panel accepted the advice of the legal assessor, which included reference to Rule 32(3).

The panel took into account that the Notice of Resuming Hearing provided details of the dates, time, and venue of the resuming hearing.

In the light of all of the information available, the panel was satisfied that Miss Hwayire has been served with the Notice of the Resuming Hearing in accordance with the requirements of Rule 32(3).

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 Miss Hwayire's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised the NMC's 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 judgement.

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

Submissions on misconduct

Mr Khan invited the panel to take the view that the facts found proved amount to misconduct. He submitted that Miss Hwayire's actions fell below the standards expected by 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) and the nursing profession in general.

Mr Khan submitted that Miss Hwayire's actions and failings set out in the charges found proved were not just a series of one-off incidents. He highlighted that there were eight charges, seven of which took place within a one month period in 2020, with another taking place two years later, despite regular regulatory involvement.

Mr Khan submitted that the residents of the Home were vulnerable and the majority of charges related to poor, incorrect or failed administration of medication, which could have led to patient harm. He submitted that there was a genuine attitudinal concern in respect of Miss Hwayire's behaviour in that she:

- Adopted a "*blame game*" approach towards fellow colleagues, not understanding that other colleagues appeared to be investigated and dealt with in the same way;
- Shouted aggressively at Witness 1 and called her incompetent;
- Accused Witness 2 (someone Miss Hwayire had never met) of racism without merit; and
- Was rude and unprofessional towards her regulator.

Mr Khan submitted that it was clear that Miss Hwayire had a long way to go to solve these issues. He submitted that in addition, there were very real data protection concerns, and at no point did Miss Hwayire appear to have any regard to the consequence of her actions on the residents. Mr Khan acknowledged Miss Hwayire's position that she had no intention to share the images, but took the photographs in order to send them to the RCN because she felt unsupported. He submitted, however, that Miss Hwayire's conduct demonstrated that she had difficulty dealing with criticism.

Mr Khan identified the specific, relevant standards of the Code where Miss Hwayire's actions amounted to misconduct.

Submissions on impairment

Mr Khan 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 maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and *Cohen v General Medical Council* [2008] EWHC 581.

Mr Khan submitted that Miss Hwayire's fitness to practise is impaired by reason of her misconduct.

Mr Khan invited the panel to consider the three questions in the case of *Cohen v GMC* in its assessment of current impairment:

1. Is the misconduct easily remediable?
2. Has the misconduct been remedied?
3. Is the misconduct likely to be repeated?

Mr Khan submitted that there was undoubtedly a balancing exercise between the public interest and the impact on Miss Hwayire. However, he submitted that all the evidence pointed towards Miss Hwayire's fitness to practise being currently impaired.

Mr Khan referred to the "test" endorsed in the case of *CHRE v NMC and Grant* and submitted that the first three limbs were engaged in this case. He submitted that charges 1, 2, 3, 4 and 5 related to Miss Hwayire's failure to administer the correct medication to residents or her failure to sign for medication which could have led to further medication errors. Mr Khan submitted that throughout Miss Hwayire's responses, it was largely clear that she did not trust her regulator, and she had not engaged in the most co-operative way as shown in charge 8. He drew the panel's attention to some of Miss Hwayire's responses which state that she has not been able to address the issues because she is not practising as a nurse. Mr Khan submitted that there was very little evidence of insight from Miss Hwayire.

Mr Khan referred the panel to Miss Hwayire's Fitness to Practice Reflective Account Form dated 19 May 2022. He submitted an interim conditions of practice order did not prevent Miss Hwayire from obtaining nursing jobs, subject to an employer's decision making. Mr Khan submitted that she had also not shown improved insight through training courses which are readily available.

Mr Khan then referred to Miss Hwayire's most recent correspondence to the NMC in the email dated 16 April 2024 which stated:

> '*...I see no point in attending as I am [PRIVATE] and the conditions haven't been corrected by the managers so that they removed*
> *The pill mistakes fir 5 nurses requires corrections in form of assessment which can't be corrected if [PRIVATE] [sic]*'

Mr Khan submitted that there was effectively a "*stalemate*" in terms of what Miss Hwayire's position is in relation to strengthening her practice. He submitted that four years after the incidents, Miss Hwayire's position is that the other five nurses involved also require corrections.

Mr Khan submitted that to Miss Hwayire's credit, she had completed "*teaching qualifications*", but this did not advance her case in relation to impairment. He submitted that there was some acknowledgement of prioritising with respect and dignity, but this was generic and vague.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *R (On the application of Remedy UK) v GMC* [2010] EWHC 1245 (Admin), *Calhaem v GMC* [2007] EWHC 2006 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *CHRE v NMC and Grant*, and *Cohen v GMC*. The legal assessor also referred the panel to the NMC guidance on misconduct, impairment and insight and strengthened practice.

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)* 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.'*

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 Miss Hwayire's actions did fall significantly short of the standards expected of a registered nurse, and that Miss Hwayire's actions amounted to breaches of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately:

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.5 take all steps to make sure that records are kept securely

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

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times'.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered Miss Hwayire's conduct at charges 1, 2, 3, 4 and 5, which related to medication administration and record keeping errors on eight separate days within a one-month period. The panel noted that there were seven instances of Miss Hwayire failing to administer medication correctly, and two instances of her not recording accurately, including writing a deceased resident's medication onto the MAR chart of another resident. The panel considered that medication administration and record keeping are fundamental parts of nursing practice therefore, Miss Hwayire's pattern of poor medication practice left vulnerable residents at risk of harm. It was of the view that colleagues and patients would expect medication to be administered safely and corresponding records to be accurate. The panel therefore determined that Miss Hwayire's conduct at charges 1, 2, 3, 4 and 5 fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

In relation to charges 6a and 6b, the panel considered that Miss Hwayire's reaction to Witness 1 raising the issue of medication errors by shouting aggressively and telling her that she was incompetent was a wholly inappropriate and disproportionate response. In the panel's view, Miss Hwayire's response was a very defensive and negative way of responding to feedback from a senior colleague. The panel determined that Miss Hwayire's behaviour would be regarded as reprehensible by fellow practitioners. On that basis, the panel decided that Miss Hwayire's conduct at charges 6a and 6b fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

The panel noted that Miss Hwayire's conduct at charge 7 related to a clear breach of confidentiality. There was no information before the panel as to how many photographs Miss Hwayire took, but what was clear was that she had taken photographs of residents' MAR charts. The information before the panel was that Miss Hwayire had then distributed these photographs to the RCN with the intention that it would support her case. The panel has found that these photographs included more than just the '*signature space*' and would have revealed residents' personal information.

The panel considered that by taking and storing photographic images of residents' MAR charts on her personal mobile telephone, Miss Hwayire failed to respect patient dignity and confidentiality. The panel therefore found that Miss Hwayire's behaviour at charge 7 fell seriously short of the conduct and standards expected of a registered nurse to keep patient records private, and amounted to misconduct.

The panel next considered Miss Hwayire's conduct at charge 8. It noted that Miss Hwayire had sent an inappropriate email to the NMC containing graphical representations or 'emoji's' of faeces some two years after the events which led to the referral. In the panel's view, this indicated that it was not a 'heat of the moment' communication. The communication was rude and offensive and could have upset the recipient. The panel determined that Miss Hwayire behaved entirely inappropriately by communicating with her regulator in this way, and by doing so, she failed to uphold professional standards. The panel determined that Miss Hwayire's actions at charge 8 fell 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, Miss Hwayire's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC's guidance on impairment in the Fitness to Practise Library, updated on 27 February 2024, which states:

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

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

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

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

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test", in her fifth report from *Shipman*, which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *...'*

The panel was satisfied that limbs a), b) and c) were engaged in this case. It found that residents were put at risk of harm by Miss Hwayire's misconduct. Miss Hwayire's misconduct had breached the fundamental tenets of the nursing profession by failing to ensure residents' safety and best interests were maintained at all times, and had brought the nursing profession into disrepute.

The panel recognised that it must make an assessment of Miss Hwayire's fitness to practise as of today. This involves not only taking account of past misconduct but also what has happened since the misconduct came to light and whether Miss Hwayire would pose a risk of repeating the misconduct in the future.

The panel had regard to the principles set out in the case of *Cohen v GMC* and considered whether the concerns identified in Miss Hwayire's nursing practice were capable of being addressed, whether they have been addressed and whether there was a risk of repetition of a similar kind at some point in the future. In considering those issues the panel had regard to the nature and extent of the misconduct and considered whether Miss Hwayire had provided sufficient evidence of insight and strengthened practice.

In its consideration of insight the panel noted that during the probationary meeting and investigatory meeting at the Home in 2020 and in subsequent responses to the concerns, Miss Hwayire admitted to some of her medication errors, but in other instances, she had made firm denials and tried to deflect the blame by either pointing out other people's mistakes or emphasising other matters. The panel considered that Miss Hwayire had demonstrated a combative, inflexible and aggressive attitude, as well as a lack of willingness to learn from or listen to concerns raised by colleagues. Miss Hwayire then went on to act in a disrespectful manner towards her regulator over two years after the issues at the Home.

The panel noted that Miss Hwayire had not demonstrated an understanding of how her actions put the residents at a risk of harm, why what she did was wrong and how this impacted negatively on her colleagues, the Home and the reputation of the nursing profession. The panel had not seen evidence of remorse from Miss Hwayire, nor had it seen evidence that would sufficiently demonstrate how she would handle the situation differently in the future.

The panel therefore found that Miss Hwayire demonstrated very limited insight into her failings.

The panel was satisfied that some of the misconduct is capable of being addressed through relevant training. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Hwayire has taken steps to strengthen her practice. The panel was mindful that Miss Hwayire's misconduct consisted of a pattern of repeated errors in the fundamental areas of medication administration and record keeping. Despite feedback and an offer to undertake a competency assessment at the time of the concerns, Miss Hwayire's attitude was defensive and combative.

The panel took into account that there was some evidence of eLearning completed by Miss Hwayire in 2022, some of which would be relevant to the areas of misconduct,

including '*Handling Medication & Avoiding Drug Errors*'. It also noted that since the referral, Miss Hwayire has engaged with the NMC.

However, the panel noted that Miss Hwayire has not practised as a nurse since working at the Home. Further it considered that throughout her reflections and communications with the NMC, Miss Hwayire has repeated her view that the interim conditions of practice that have been in place since 2020 have meant that she has not been able to gain employment in order to strengthen her practice. In her view, this means that she will not be able to strengthen her practice until the interim conditions of practice are removed. There is no up to date evidence to suggest that Miss Hwayire has strengthened her practice sufficiently through additional training or nursing practice.

The panel was less satisfied that the misconduct found at charges 6 to 8 was capable of being addressed easily.

As regards charges 6 and 8, the panel noted that there had been two occasions on which Miss Hwayire had engaged in aggressive and/or rude communications with the deputy manager of the Home and then her regulator when her professionalism as a nurse was being explored. The panel was concerned that this could demonstrate deep-seated attitudinal problems. Miss Hwayire had not addressed in her communications to the NMC how and why she would behave differently in the future.

In relation to charge 7, it would have been obvious to Miss Hwayire how completely unacceptable it was to take photographs of residents' MAR charts for the purpose of assisting her in any investigation or disciplinary matter. The panel noted that Witness 2 had verbally warned Miss Hwayire about the implications of taking photographs and storing residents' information on her personal mobile telephone, reminded her about GDPR and asked her to delete the images, but Miss Hwayire did not respond appropriately to this. Instead, she said she had the right to take and store the images.

The panel concluded that Miss Hwayire cannot currently practise safely, kindly and professionally.

The panel found that there is a risk of repetition and that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required. This is because a well-informed member of the public would be concerned to learn that Miss Hwayire made repeated errors in fundamental areas of nursing practice which put residents at risk of harm. These included errors in medication administration and record keeping, as well as breaching patient confidentiality. In addition, she had behaved aggressively towards a colleague and had been rude to her regulator. There was no evidence to show that these concerns had been meaningfully addressed.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also found Miss Hwayire's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a substantive conditions of practice order for a period of 12 months. The effect of this order is that Miss

Hwayire's name on the NMC register will show that she is subject to a conditions of practice order and anyone who enquires about her registration will be informed of this order.

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

Submissions on sanction

In the Notice of Hearing, dated 10 January 2024, the NMC had advised Miss Hwayire that it would seek the imposition of a 12-month conditions of practice order with review if the panel found Miss Hwayire's fitness to practise currently impaired. Mr Khan invited the panel to impose this substantive order.

Mr Khan submitted that by way of aggravating features in this case, Miss Hwayire had made multiple errors within a short period of time in 2020, most of which contained an element of risk of patient harm. In addition, he highlighted that Miss Hwayire had demonstrated an uncooperative attitude towards colleagues and the perpetuation of a "*blame game*" in respect of medication errors. Mr Khan submitted that since then, none of the concerns had been put right and there had been a lack of insight from Miss Hwayire into her failings.

Mr Khan submitted that a conditions of practice order, should Miss Hwayire choose to secure a nursing job, would address the numerous breaches in this case. He submitted that the current interim conditions of practice order, which was imposed on 5 December 2023, strikes a balance between protecting the public and developing Miss Hwayire's insight. Mr Khan submitted that given the nature of Miss Hwayire's errors, greater supervision is required, and she would need to focus on her ability to keep clear and accurate records, administer medication correctly, keep to data protection obligations and maintain effective communications. He submitted that taking these matters together it was

clear that Miss Hwayire would be assisted by having a framework such as a conditions of practice order in place to strengthen her practice.

Mr Khan summarised the current interim conditions of practice order for the panel and invited the panel to consider conditions of practice in similar terms, namely that Miss Hwayire:

- must not manage or administer medication until assessed as competent to do so;
- must always work with another nurse;
- must meet with her line manager to discuss her clinical practice with particular reference to the areas of concern, and provide a report from her line manager commenting on these meetings to the NMC; and
- must update the relevant people.

Mr Khan informed the panel that there had been no previous Fitness to Practise findings against Miss Hwayire.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Miss Hwayire'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 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.

During the course of the panel's deliberations, it received three emails from Miss Hwayire to the NMC dated 3 May 2024 forwarding correspondence with prospective employers

about nursing roles she has applied for. The panel, in considering sanction, took these into consideration.

The panel took into account the following aggravating features:

- There were multiple medication errors within a short period of time in 2020
- Miss Hwayire has not demonstrated meaningful insight into her failings
- Miss Hwayire's conduct put patients at risk of harm.

The panel did not identify any mitigating features in this case.

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 the public protection 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 Miss Hwayire'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 Miss Hwayire's misconduct 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 placing conditions of practice on Miss Hwayire's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *...;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel took into account Miss Hwayire's reflections and the communications that it had seen between her and the NMC. It noted that Miss Hwayire accepted that she made some clinical errors but showed no insight into her failings, why she made the errors in the first place or the risk of harm they may have caused to residents at the Home. The panel also noted that the reflections did not address the impact of her failings on the reputation of the nursing profession.

The panel considered that Miss Hwayire had not addressed her behaviour set out in the non-clinical charges (charges 6a, 6b, 7 and 8), nor had she acknowledged how far her overall conduct fell short of the professional standards expected of a registered nurse.

The panel noted that Miss Hwayire has not been able to engage with the interim conditions of practice order in the period since it was imposed as she has not worked as a registered nurse. Miss Hwayire has consistently asserted that she cannot secure nursing employment because of the interim conditions of practice and that they need to be removed.

The panel had no evidence of a change in Miss Hwayire's attitude towards taking responsibility for the charges found proved. In addition, it determined that she has not undertaken sufficient training to address all areas of the misconduct in this case.

However, the panel was satisfied that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

As the panel has noted, it was concerned that Miss Hwayire's misconduct could demonstrate deep-seated attitudinal problems, but the relevant charges found proved (charges 6a, 6b, 7 and 8) are isolated, different in their nature and it had been provided with no evidence that might establish a consistent pattern of harmful behaviour relating to these charges. The panel was of the view that by formulating and imposing workable conditions of practice on Miss Hwayire's practice, it would give her the opportunity to demonstrate that any attitudinal matters have been addressed.

The panel considered that there were identifiable areas of Miss Hwayire's practice that are in need of assessment and retraining, namely medication management, record keeping and information governance. The panel had seen no evidence of general incompetence. It noted that there was some indication that Miss Hwayire is willing to retrain, in light of her completion of online training courses covering various areas of nursing practice in December 2022, and outside of nursing practice she also completed a Professional Graduate Certificate in Education in July 2022.

The panel determined that patients would not be put in danger either directly or indirectly as a result of conditions of practice, and that conditions would protect patients during the period they are in force. Further, conditions could be created that can be monitored and assessed.

The panel was of the view that it was in the public interest that, with appropriate safeguards, Miss Hwayire should be able to return to practise as a nurse. It determined that it would be disproportionate to remove Miss Hwayire from the register.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Miss Hwayire's case. It considered that either of these sanctions would prevent Miss Hwayire from securing employment in a nursing role, and would impede her fully addressing the concerns, developing her skills and demonstrating safe practice in order for her to return to unrestricted practice in the future. The panel was satisfied that Miss Hwayire's misconduct was not fundamentally incompatible with remaining on the register.

In addition, the panel was satisfied that a suspension order or a striking-off order were not the only sanctions that would protect patients nor were they required in the public interest and would be unduly punitive in Miss Hwayire's case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will maintain public confidence in the nursing profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

<u>For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.</u>

1. You must ensure that you are supervised by another registered nurse of the same grade or above any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, a registered nurse.

2. You must be directly supervised by another registered nurse of the same grade or above any time you are engaged in the administration and management of medication until you have been formally assessed as competent by a registered nurse of the same grade or above.
   You must provide your case officer with details of your competency assessment upon successful completion.

3. You must meet with your line manager, supervisor, or their nominated deputy or mentor monthly to discuss your clinical practice with particular reference to:
   - Medication administration and record keeping
   - Communication with colleagues including how you respond to feedback on any concerns about your practice
   - General Data Protection Regulation (GDPR) and information governance compliance.

4. Prior to any substantive order review you must send your NMC case officer a report from your line manager, supervisor, or their nominated deputy or mentor which comments on your clinical practice with particular reference to the areas identified in condition 3.

5. You must complete training in information governance, including GDPR, relevant to your role as a nurse.
   Prior to any substantive order review you must send your NMC case officer documentary evidence of your successful completion of this training.

6. You must keep the NMC informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment.
b) Giving your case officer your employer's contact details.

7. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study relating to nursing.

9. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

a) Any current or future employer.
b) Any educational establishment.
c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 12 months. The panel concluded that such a period would be adequate to provide Miss Hwayire with the opportunity to secure employment in a nursing role to strengthen her practice, and demonstrate developed insight by reflecting on her past misconduct and future practice.

Before the order expires, a panel will hold a substantive order review hearing to see how Miss Hwayire has complied with the order. At the review hearing the panel may allow the order to lapse upon expiry, it may make another order, it may extend the period for which the order has effect, and it may vary any of the conditions.

The panel considered it appropriate to indicate to Miss Hwayire that by strengthening her practice through securing employment in a nursing role, complying with the conditions of practice order, and developing insight into her failings and the behaviours that led to the incidents set out in the charges found proved, a future panel may consider it appropriate to remove the conditions of practice in order for Miss Hwayire to return to unrestricted practice.

Any future panel reviewing this case would be assisted by:

- Miss Hwayire's engagement and attendance at the substantive order review hearing.
- A detailed written reflective account which addresses the concerns found proved and demonstrates Miss Hwayire's insight into the circumstances surrounding the concerns, why she acted as she did, how she has reflected on that and how she would act in the future in a similar situation.
- References and testimonials from colleagues, employers and managers from any

paid or unpaid work.

- Evidence of any mandatory training or additional training and learning relating to nursing.

This will be confirmed to Miss Hwayire in writing.

Interim order

As the substantive conditions of practice order cannot take effect until the end of the 28-day appeal period or the conclusion of any appeal, 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 Miss Hwayire's own interests until the substantive conditions of practice sanction takes effect. 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 Khan. He invited the panel to make an interim conditions of practice order for a period of 18 months to cover any appeal period until the substantive order takes effect. He submitted that such an order is necessary for the protection of the public and is otherwise in the public interest.

Decision and reasons on interim order

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

The panel concluded that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The

conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to ensure that Miss Hwayire cannot practise unrestricted before the substantive conditions of practice order takes effect. This will cover the 28 days during which an appeal can be lodged and, if an appeal is lodged, the time necessary for that appeal to be determined.

If no appeal is applied for, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Miss Hwayire is sent the decision of this hearing in writing.

That concludes this determination.