Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Friday 16 – Wednesday 21 July 2021

Virtual meeting

Name of registrant:	Helen Mboo Ekadi
NMC PIN:	03L0772O
Part(s) of the register:	Registered Midwife (27 July 2005) Registered Nurse – Sub Part 1 - Adult Nursing – (19 December 2003)
Area of registered address:	Hertfordshire
Type of case:	Misconduct
Panel members:	Anne Owen (Chair, registrant member) John McGrath (Registrant member) David Boden (Lay member)
Legal Assessor:	Nigel Mitchell
Panel Secretary:	Catherine Acevedo
Facts proved:	Charges 1a(i), 1b(i), 1b(ii), 1b(iii), 1b(iv), 1b(v), 3a, 3b, 3d, 3e, 3f, 3h(i), 3h(ii), 3h(iii), 4a, 4b, 5a(i), 5a(ii), 5a(iii), 5a(iv), 6a(i), 6a(ii), 6a(iv), 6b(i), 6b(ii), 6b(iii)
Facts not proved:	Charges 1a(ii), 1a(iii), 2, 3c, 3g, 5b, 5c, 6a(iii),
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that Mrs Ekadi was not in attendance and that the Notice of Meeting had been sent to Mrs Ekadi registered email address on 3 June 2021.

The panel took into account that the Notice of Meeting provided details of the allegations and that the matter would be heard on or after 8 July 2021.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mrs Ekadi has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse,

1. Whilst working at North Devon District Hospital

a. On 28 April 2018, in respect of Patient C:

i) upon being informed that Patient C had a NEWS score of 12 and required a doctor's review, you did not take any action and/or escalate concerns to a doctor;

ii) upon being informed by Colleague A that Patient C was for "palliative care and "could deteriorate quickly" or words to that effect, you did not take any action and/or escalate concerns to a doctor;

iii) inappropriately asked Colleague A to assist you as a second checker whilst she was in the process of escalating concerns for Patient C;

b. On 1 May 2018, in respect of Patient BH you:

i) forced Patient BH on to the bed by placing one hand on her head and one hand on her stomach;

ii) inappropriately used six tall backed chairs around Patient BH's bed as a restrictive barrier;

iii) called the patient "a baby" on one or more occasions;

iv) said to Colleague B that "if they act like toddlers then that is how they should be treated" or words to that effect;

v) slept on duty on one or more occasions.

2. On 9 November 2018, whilst working at Gloucester Hospital, Ward 8B, you inappropriately grabbed and/or held on to Patient MB whilst assisting her back to bed.

3. On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

a. Refused to sit in the bay where Patient SA was based.

b. Sat outside the bay.

c. Did not interact with Patient SA.

d. Left Patient SA unattended on one or more occasions.

e. Did not notice that Patient SA had pulled out his cannula, or in the alternative, you did not take appropriate action upon noting that Patient SA had pulled out his cannula.

f. Left Patient SA in clothing which was soaked in urine.

g. Incorrectly scored Patient SA's CIWA score as 5.

h. In respect of one or more unknown patients you:

i) were involved in a near miss drug error, in that you attempted to administer Amitriptyline at 06:00 when it had been administered at 22:00 the previous night;

ii) demonstrated an inability to safely follow instructions on drug administration charts;

iii) upon being informed that an unknown patient was experiencing chest pain and it was a medical emergency, you did not respond and/or take appropriate action.

4. On 15/16 November 2018, whilst working on Derriford Hospital you:

a. Did not administer prescribed antibiotics to Patient DH at 02:00 as required.

b. Requested the prescribed antibiotics at 06:00, four hours after it was due.

5. On or around 7 December 2018, whilst working at Alexandra Hospital, Ward 17:

a. In respect of an unknown patient, you:

i) inappropriately tilted the patient's head back and tipped tablets into their mouth;

ii) used force to administer the medication;

iii) ignored the patient's wishes to refuse the medication;

iv) when informed by Colleague C to stop administering the medication you did not stop or respond.

b. Roughly handled Patient AM whilst assisting him to the bathroom.

c. Shouted at Patient AM.

6. Whilst working at Alexandra Hospital, Ward 17 on one or more dates between 4 and 9 December 2018, you:

a. Demonstrated inappropriate/poor communication skills in that you:

i) when asked a question by a one or more unknown patients and/or family members stated that "I don't know, I don't work here" or words to that effect;

ii) responded inappropriately to Patient AM when he refused to eat the meal option;

iii) did not offer Patient AM an alternative meal when he informed you he did not want the meal option;

iv) insisted Patient AM eat the meal option;

b. In respect of Patient BE you:

i) on one or more occasions, did not administer his Parkinson's medication on or around 12:00 as prescribed;

ii) placed six tablets in his mouth with water causing him to choke/almost choke;

iii) when questioned about your actions by Person A you said "well he has to have his tablets" or words to that effect.

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

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case together with the responses and material provided by Mrs Ekadi.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Person A — Person A.
- Colleague A: — Staff Nurse, Victoria Ward, North Devon District Hospital.
- Colleague B: — Bank Healthcare Assistant (HCA) at North Devon District Hospital.
- Colleague C: — Bank staff Nurse, Alexandra Hospital.
- Colleague D: — Advanced Nurse Practitioner at Gloucester Royal Hospital.
- Colleague E: — Junior Sister - Tamar Ward, Derriford Hospital.
- Colleague F: — Junior Sister - Moorgate Ward, Derriford Hospital.
- Colleague G — Ward Sister - Ward 17, Alexandra Hospital.

- Witness 1 — Clinical Matron - North Devon District Hospital.
- Witness 2 — Ward Manager – Ward 8B, Gloucester Royal Hospital
- Witness 3 — Clinical Manager of Temporary Staffing - Gloucester Royal Hospital
- Witness 4 — Junior Sister -Tamar Ward, Derriford Hospital.
- Witness 5 — Ward Manager – Clinical Decision Unit (CDU), Derriford Hospital.
- Witness 6 — Trainee Advanced Clinical Practitioner for Neurosurgery – Moorgate Ward, Derriford Hospital
- Witness 7 — Junior Sister – Trauma and Orthopaedic Ward, Worcester Hospital.
- Witness 8 — Divisional Director of Nursing - Worcestershire Acute Hospitals NHS Trust.

Background

Mrs Ekadi was first admitted to the register of nurses in 2003 and the register of midwives in 2005.

At the time of the concerns raised in the referral, Mrs Ekadi was working as an Agency nurse for TXM Healthcare Agency at North Devon District Hospital ('North Devon'). A referral was made by the Clinical Matron at Northern Devon healthcare NHS Trust on 2 May 2018.

The NMC were made aware of further concerns regarding Mrs Ekadi's practice in February 2019. At the time of these concerns, Mrs Ekadi was working as an Agency nurse for ID Medical at three different hospitals; Gloucester Royal Hospital ('Gloucester'), Derriford Hospital ('Derriford') and Alexandra Hospital ('Alexandra').

The concerns therefore span Mrs Ekadi's employment at four hospitals and relate to 13 patients over an 8 month period (April - December 2018).

Mrs Ekadi worked a total of three shifts on the Victoria ward at North Devon on 28 April 2018, 29 April 2018 and 1 May 2018. The Victoria ward is primarily a cardiology ward but does provide mixed medical care for a range of patients, including palliative care. During these shifts Mrs Ekadi is alleged to have:

- handled patients roughly;
- communicated inappropriately with patients and their families;
- did not provide the required 1:1 care;
- failed to recognise a deteriorating patient; and
- inappropriately restrained a patient.

Following these concerns, Mrs Ekadi was not allocated any further shifts at North Devon.

Mrs Ekadi then commenced employment with ID Medical Agency on 5 October 2018. Between October and November 2018, she worked a total of four shifts at Gloucester, on the Respiratory ward ('Ward 8B'). Whilst working on Ward 8B, it is alleged that Mrs Ekadi roughly handled patients and communicated inappropriately with patients and their families.

Following these concerns, Mrs Ekadi was asked to provide a reflective statement. Her reflective statement was only deemed to be acceptable following her second attempt. Due to this, she was placed on a permanent shift ban from Gloucester.

In November 2018, Mrs Ekadi undertook shifts on multiple wards at Derriford. Concerns were raised on two of these wards. One ward was Tamar ward ('Tamar'). Tamar is a short stay ward, however, as the Ward is placed next to the Medical Assessment Unit, it often takes patients who have not been assessed by a consultant. These patients are deemed to be higher risk patients. The other ward was Moorgate ward ('Moorgate'). Moorgate is a neurosurgical ward.

During Mrs Ekadi's time working on those wards it is alleged that she did not:

- provide the 1:1 care required;
- failed to act on signs of deterioration;
- left a patient sodden and soiled;
- failed to act in an emergency; and
- made errors and demonstrated lack of knowledge in regard medication administration.

Following these concerns she was placed on a shift ban from Derriford.

In December 2018, Mrs Ekadi was booked for a four week block placement at another Hospital, Alexandra, on ward 17 ('W17'). W17 specialises in orthopaedics and trauma, which means the patients are highly dependent and require a high level of care.

During Mrs Ekadi's time working on W17 it is alleged that she:

- inappropriately communicated with patients and their families;
- demonstrated rough handling of patients; and
- demonstrated medication administration errors.

Following these concerns being raised, it was mutually agreed for Mrs Ekadi to finish her four week block on W17 early and to not return to Alexandra on any other ward.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by both the NMC and Mrs Ekadi.

The panel then considered each of the disputed charges and made the following findings.

Charge 1a(i)

Whilst working at North Devon District Hospital

a. On 28 April 2018, in respect of Patient C:

i) upon being informed that Patient C had a NEWS score of 12 and required a doctor's review, you did not take any action and/or escalate concerns to a doctor.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague A. Colleague A says in her statement *"I informed the Registrant that Patient C was scoring a 12 and that she would need to be seen by the doctor on call. The Registrant came to Patient C's bedside where I showed her the NEWS chart and the score of 12, the Registrant agreed that Patient C needed to be seen by a doctor. The registrant then walked back to Patient D's bedside and continued to administer the medication that she had prepared".*

The panel was satisfied that Mrs Ekadi had not taken any action when she was informed about Patient C requiring a doctor's review. The panel therefore found charge 1a(i) proved.

Charge 1a(ii)

Whilst working at North Devon District Hospital

a. On 28 April 2018, in respect of Patient C:

ii) upon being informed by Colleague A that Patient C was for "palliative care" and "could deteriorate quickly" or words to that effect, you did not take any action and/or escalate concerns to a doctor;

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Colleague A. Colleague A said in her statement that the doctor had assessed Patient C and made the decision to palliate her. Colleague A stated *"After receiving this information, I informed the Registrant of the doctor on call's plan for Patient C…I stated to the Registrant that because I had escalated Patient C for review and I had discussed her case with the doctor on call that I would be happy to contact the patients relatives via telephone to inform them of the situation".*

The panel considered that Patient C had not been under Mrs Ekadi's care at this point and so when she was informed about the doctor on calls' decision to palliate Patient C, Mrs Ekadi did not have to take any action or escalate concerns to a doctor. Further there was no need for Mrs Ekadi to contact a doctor as Colleague C had already done so. The panel therefore found charge 1a(ii) not proved.

Charge 1a(iii)

Whilst working at North Devon District Hospital

a. On 28 April 2018, in respect of Patient C:

iii) inappropriately asked Colleague A to assist you as a second checker whilst she was in the process of escalating concerns for Patient C;

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Colleague A. Colleague A stated *"The Registrant approached me at the nurse's station to ask me if I could assist her to be the second checker in the administration of a controlled drug. I do not know if the Registrant knew at the time that I was completing paperwork in relation to Patient C. However, I explained to the Registrant that I was in the process of escalating Patient C, for an urgent medical review and that I was unable to assist her as the second checker in the administration of a controlled drug at that time".*

The panel considered that although there was evidence that Mrs Ekadi had asked Colleague A to assist her as second checker, the panel was not satisfied that this request had been inappropriate. The panel therefore found charge 1a(iii) not proved.

Charge 1b(i)

Whilst working at North Devon District Hospital

b. On 1 May 2018, in respect of Patient BH you:

i) forced Patient BH on to the bed by placing one hand on her head and one hand on her stomach;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague B. She said in her statement *"I saw the Registrant with one hand on Patient BH's head and one hand on her stomach. The registrant was forcing Patient BH's head back into her bed and attempting to push her from the middle of the bed toward the top/head of the bed".*
The panel also had regard to an incident form completed in relation to this charge.

In Mrs Ekadi's reflective statement she wrote *"…as I turned my back, I found her on top the bed rail trying to fall so I supported her back into the bed…"*

The panel was satisfied that on the balance of probabilities that Mrs Ekadi had forced Patient BH on to the bed in the way described in the charge. It therefore found charge 1b(i) proved.

Charge 1b(ii)

Whilst working at North Devon District Hospital

b. On 1 May 2018, in respect of Patient BH you:

ii. inappropriately used six tall backed chairs around Patient BH's bed as a restrictive barrier;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague B. She said in her statement *"The Registrant had also used six tall-backed hospital chairs and positioned three on each side of Patient BH's bed as a sort of restrictive barrier to confine her to her bed".*

The panel was satisfied that Mrs Ekadi had inappropriately used six tall-backed chairs in the way described in the charge. It therefore found charge 1b(ii) proved.

Charge 1b(iii)

Whilst working at North Devon District Hospital

b. On 1 May 2018, in respect of Patient BH you:

iii. called the patient "a baby" on one or more occasions;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague B. She said in her local statement that "*The Registrant kept calling the patient a baby and telling me they act like toddlers and babies that's how we should treat them".*

The panel was satisfied with Colleague B's account that Mrs Ekadi called Patient BH a baby on one or more occasions. The panel therefore found charge 1b(iii) proved.

Charge 1b(iv)

Whilst working at North Devon District Hospital

b. On 1 May 2018, in respect of Patient BH you:

iv. said to Colleague B that "if they act like toddlers then that is how they should be treated" or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague B. She said in her local statement that "[*Mrs Ekadi] kept calling the patient a baby and telling me they act like toddlers and babies that's how we should treat them".*

The panel also had regard to the incident form that was completed in regard to this incident.

The panel was satisfied with Colleague B's account. The panel therefore found charge 1b(iv) proved.

Charge 1b(v)

Whilst working at North Devon District Hospital

b. On 1 May 2018, in respect of Patient BH you:

v) slept on duty on one or more occasions.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague B. She said in her witness statement *"I went on break and left the Registrant to oversee the ward. She was the only person allocated to the bay during the time I was on my break. She was solely responsible for the patients in the bay at that time. When I returned, I found the Registrant asleep. I woke the Registrant and explained that she needed to keep an eye out for all the patients in the bay at all times".*

Mrs Ekadi in her reflective statement, denies being asleep saying that she had elevated her leg on a chair whilst calculating fluid charts. The panel considered that her denial of the charge was insufficient and it preferred Colleagues B's version of events.

The panel was satisfied on the balance of probabilities that Mrs Ekadi had been asleep on duty. It therefore found charge 1b(v) proved.

Charge 2

On 9 November 2018, whilst working at Gloucester Hospital, Ward 8B, you inappropriately grabbed and/or held on to Patient MB whilst assisting her back to bed.

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Colleague D, an Advanced Nurse Practitioner, who had seen Mrs Ekadi with Patient MB. He said in his witness statement that the way in which Mrs Ekadi was holding Patient MB could only be described as 'peculiar'. He did not remember the incident or how Mrs Ekadi was holding Patient MB but did remember that it was "and odd way to hold someone". He had spoken to Mrs Ekadi and stated *"Despite considering what I saw at the time as a concern, I did not deem it serious enough to escalate as I believed the Registrant took on board what I said…I considered the mishandling afforded by the Registrant and my interaction and discussions with the Registrant to be more of an educational and learning interaction for the Registrant".*

Witness 9 emailed the temporary staffing manager, Witness 3 saying *"she was very physical with her patient, physically man handling her back to the bed rather than guiding and asking. Grabbing her trying to pull the patient when she wanted the patient to go".* This information was not supported by a witness statement and did not identify the patient as Patient MB and so consequently the panel gave it less weight.

Mrs Ekadi wrote in her amended reflective statement *"…I then went after her to prevent her from falling. In the process one of the male nurses walked into the Ward and told me not to hold her so that she will not fall".*

The panel was satisfied with Colleague D's account of the events and determined, on the balance of probabilities, that you had not inappropriately grabbed or held Patient MB. It therefore found charge 2 not proved.

Charge 3a

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

a. *Refused to sit in the bay where Patient SA was based.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague E. She said in her witness statement *"The bay that Patient SA was being cared for in was a six bedded bay. Due to the size of the bay, it would be expected that a nurse would be present inside the bay. The Registrant refused to sit in the bay and instead took it upon herself to sit outside by the door".*

Colleague E also described the bay stating that there were two patients and their equipment between Patient SA and the door. This meant that Mrs Ekadi would not be able to clearly see Patient SA, especially when the lights were turned off. She further stated that when providing one to one care the nurse should sit at Patient SA's bedside.

In her second reflective piece Mrs Ekadi wrote that she sat outside the bay because this is where the day sister had told her to sit when she had taken the handover. The panel determined that the expectation was that Mrs Ekadi would sit at Patient SA's bedside and not outside of the bay and therefore found charge 3a proved.

Charge 3b

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

b. *Sat outside the bay.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague E. She said in her witness statement *"The bay that Patient SA was being cared for in was a six bedded bay. Due to the size of the bay, it would be expected that a nurse would be present inside the bay. The Registrant refused to sit in the bay and instead took it upon herself to sit outside by the door".*

The panel was satisfied with Colleague E's version of events. The panel determined that Mrs Ekadi sat outside the bay and therefore found charge 3a proved.

Charge 3c

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

c. Did not interact with Patient SA.

This charge is found not proved.

In reaching this decision, the panel considered that there was insufficient evidence to demonstrate that you had not interacted with Patient SA. The panel therefore found charge 3c not proved.

Charge 3d

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

d. Left Patient SA unattended on one or more occasions.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague E. She said in her witness statement *"the Registrant went to the toilet approximately eight times during the shift and wandered around the ward in and out of the staffroom making herself multiple cups of tea. Again, this was a concern because Patient SA required 1:1 supervision and his safety was not ensured whilst she stepped away from the bay, which was unreasonably more than would be expected by any other nurse when needing to use the toilet or to get a drink".*

The panel was satisfied with Colleagues E's account that Mrs Ekadi left Patient SA unattended on multiple occasions. The panel therefore found charge 3d proved.

Charge 3e

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

e. *Did not notice that Patient SA had pulled out his cannula, or in the alternative, you did not take appropriate action upon noting that Patient SA had pulled out his cannula.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague E. She said in her witness statement "*On attending Patient SA two minutes after the Registrant had left his care for a break. I found the patient in an unacceptable state. He was laid sideways in the bed with his feet through the bars and he was wet from head to toe with urine: he had also pulled out his cannula and there was blood all over the bed*".

The panel was satisfied with Colleague E's account of how she had found Patient SA. The panel determined that you had not noticed that Patient SA had pulled out his cannula and found charge 3e proved.

Charge 3f

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

f. *Left Patient SA in clothing which was soaked in urine.*

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague E. She said in her witness statement "*On attending Patient SA two minutes after the Registrant had left his care for a break. I found the patient in an unacceptable state. He was laid sideways in the bed with his feet through the bars and he was wet from head to toe with urine".*

In her second reflective piece Mrs Ekadi denied this allegation. She wrote that she had checked the patient and asked if he would like to pass urine and his sheet was dry.

The panel preferred Colleague E's account of the condition that she had found Patient SA. The panel determined that Mrs Ekadi had left Patient SA in clothing which was soaked in urine and found charge 3f proved.

Charge 3g

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

g. Incorrectly scored Patient SA's CIWA score as 5.

This charge is found not proved.

In reaching this decision, the panel took into account the CIWA score for the shift in question and the evidence of Colleague E.

Colleague E said in her statement *"As Patient SA was assigned to the Registrant for that shift, this was her duty. It is basic nursing knowledge to complete regular CIWA on such patients and the Registrant should have known this. When the Registrant did complete the CIWA she documented the score as five".*

The panel also took into account Patient SA's clinical notes. It noted that the CIWA scores varied between 0 and 11 on the date in question. On a single occasion, four hours after Mrs Ekadi had scored the patient at 5, Colleague E assessed it at 27. This was an outlier in relation to all the other scores so the panel did not take it into account.

The panel was satisfied that although it could determine that Mrs Ekadi had scored Patient SA's CIWA score as 5, it was of the view that there was not enough information to determine that a score of 5 was incorrect. The panel therefore found charge 3g not proved.

Charge 3h(i)

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

h. In respect of one or more unknown patients you:

i) were involved in a near miss drug error, in that you attempted to administer Amitriptyline at 06:00 when it had been administered at 22:00 the previous night;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague E. Colleague E said in her statement *"A near error of medication administration was detected and avoided by myself as fortunately the Registrant could not find a Amitriptyline that was prescribed for one of her patients, Patient C and therefore asked me where to get it from. I knew that the medication she was asking for had a sedative in it, and she asked for it at 06:00 so I was able to stop this in its tracks. The drug had already been given to Patient C by myself at 22:00hrs the night before.*"

The panel was satisfied with Colleague E's detailed account of the events and determined that Mrs Ekadi was involved in a near miss drug error. The panel therefore found charge 3h(i) proved.

Charge 3h(ii)

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

h. In respect of one or more unknown patients you:

ii) demonstrated an inability to safely follow instructions on drug administration charts;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague E. Colleague E said in her statement *"Whilst completing the medication round I became increasingly concerned that the Registrant did not understand the drug chart. The charts are easy to use, but she did not understand how to use them and seemed to be confused*

about the timings to give patients their medication. In light of my concern, I showed Mrs Ekadi how to read and use the charts, but even after showcasing this, she continued to use them incorrectly".

In Mrs Ekadi's second reflective piece she wrote *"The Allegations that I am not able to read drug chart correctly is an understatement and malicious".*

The panel preferred Colleague E's detailed account of the events and determined that Mrs Ekadi had demonstrated an inability to safely follow *instructions on the drug charts*. The panel therefore found charge 3h(ii) proved.

Charge 3h(iii)

On 14 November 2018, whist working at Derriford Hospital, and upon being allocated one to one patient care for Patient SA you:

h. In respect of one or more unknown patients you:

iii. upon being informed that an unknown patient was experiencing chest pain and it was a medical emergency, you did not respond and/or take appropriate action.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague E. Colleague E said in her statement *"One of the HCA's ran into the treatment room to notify the Registrant that Patient D had chest pain and that it was a medical emergency. The registrant carried one setting up an IV so instead I ran to Patient D and the Registrant did not follow. As the Registrants ascribed patient, she should have attended to Patient D immediately'.*

In Mrs Ekadi's second reflective piece she wrote *"There was no emergency alarm to alert me as I was in another bay giving medication".*

The panel preferred Colleague E's detailed account of the events and determined that Mrs Ekadi did not respond or take appropriate action when informed that Patient D was experiencing chest pain. The panel therefore found charge 3h(iii) proved.

Charge 4a

4. On 15/16 November 2018, whilst working on Derriford Hospital you:

a. Did not administer prescribed antibiotics to Patient DH at 02:00 as required.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Colleague F. She said in her witness statement *"At 6:00 on 16 November 2018, The Registrant informed me that she could not locate Patient DH's antibiotic. The drug chart showed that Patient DH was prescribed Tazocin and Clindamycin intravenous antibiotics (Abs) and it was to be administered at 02:00".*

The panel had sight of the MAR chart which showed that although antibiotics were prescribed at 02:00 they were not administered. The panel was satisfied that the MAR chart was accurate, and that Mrs Ekadi did not administer the antibiotics at 02:00 as required. It therefore found charge 4a proved.

Charge 4b

On 15/16 November 2018, whilst working on Derriford Hospital you:

b. Requested the prescribed antibiotics at 06:00, four hours after it was due.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Colleague F. She said in her witness statement *"At 6:00 on 16 November 2018, The Registrant informed me that she could not locate Patient DH's antibiotic. The drug chart showed that Patient DH was prescribed Tazocin and Clindamycin intravenous antibiotics (Abs) and it was to be administered at 02:00".*

The panel was satisfied with Colleague F's account of the events that Mrs Ekadi requested the prescribed drugs at 06:00 which was four hours after it was due. The panel therefore found charge 4b proved.

Charge 5a(i)

5. On or around 7 December 2018, whilst working at Alexandra Hospital, Ward 17:

a. In respect of an unknown patient, you:

i. inappropriately tilted the patient's head back and tipped tablets into their mouth;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C. She said in her statement *"I watched the Registrant tilt the patient's head back by placing her hand on the patient's forehead and pushing it back. The Registrant then tipped tablets into the patient's mouth. I was too far away to see how many tablets were tipped into the patient's mouth… It was clear from where I was standing that the patient was clearly telling the Registrant he did not want to take his medication, but she seemed to ignore this which is why it seems force was used to administer the medication".*

The panel was satisfied with Colleague C's account of the event and determined that Mrs Ekadi inappropriately tilted the patients head back and tipped tablets into their mouth. The panel therefore found charge 5a(i) proved

Charge 5a(ii)

5. On or around 7 December 2018, whilst working at Alexandra Hospital, Ward 17:

a. In respect of an unknown patient, you:

ii) used force to administer the medication;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C. She said in her statement *"It was clear from where I was standing that the patient was clearly telling the Registrant he did not want to take his medication, but she seemed to ignore this which is why it seems force was used to administer the medication".* She also said *"I explained to the Registrant that she should not have pushed the patients head back with force and give him medication he did not want".*

The panel was satisfied with Colleague C's account of the event and determined that Mrs Ekadi used force to administer the medication. The panel therefore found charge 5a(ii) proved.

Charge 5a(iii)

5. *On or around 7 December 2018, whilst working at Alexandra Hospital, Ward 17:*

a. In respect of an unknown patient, you:

iii. ignored the patient's wishes to refuse the medication;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C. Colleague C said in her statement *"It was clear from where I was standing that the patient was clearly telling the Registrant he did not want to take his medication, but she seemed to ignore this which is why it seems force was used to administer the medication".*

The panel was satisfied with Colleague C's account of the event and determined that Mrs Ekadi ignored the patient's wishes to refuse the medication. The panel therefore found charge 5a(iii) proved.

Charge 5a(iv)

On or around 7 December 2018, whilst working at Alexandra Hospital, Ward 17:

a. In respect of an unknown patient, you:

iv. when informed by Colleague C to stop administering the medication you did not stop or respond.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague C. Colleague C said in her statement *"I explained to the Registrant that she should not have pushed the patients head back with force and given him medication he did not want. I said 'stop doing that' She did not respond".*

The panel was satisfied with Colleague C's account of the event and determined that Mrs Ekadi did not respond when told by Colleague C to stop administering the medication. The panel therefore found charge 5a(iv) proved.

Charge 5b

On or around 7 December 2018, whilst working at Alexandra Hospital, Ward 17:

b. Roughly handled Patient AM whilst assisting him to the bathroom.

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Colleague G. She said in her statement that *"The Registrant was seen by a doctor on the Ward to be hurrying a patient, whilst escorting him to the toilet; the Registrant did this by kicking the patients frame to move it forward and make him move quicker. I cannot recall who the doctor or the patient was".*

The panel noted that Colleague G was not a direct witness to the event but had been told about the incident by a doctor and a patient that she was unable to identify. The panel considered that the evidence was not sufficient to support finding charge 5b proved.

Charge 5c

On or around 7 December 2018, whilst working at Alexandra Hospital, Ward 17:

c. Shouted at Patient AM.

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 8.

Witness 8 said in her statement *"My understanding of the incident from Patient AM's account is that, whilst the Registrant was escorting Patient AM to the toilet she shouted at him and handled him roughly.*

The panel noted that Witness 8 was not a direct witness to the event but had been told about the incident by Patient AM who had dementia and his wife. The panel considered that the evidence was not sufficient to support finding charge 5c proved.

Charge 6a(i)

Whilst working at Alexandra Hospital, Ward 17 on one or more dates between 4 and 9 December 2018, you:

a. Demonstrated inappropriate/poor communication skills in that you:

i) when asked a question by a one or more unknown patients and/or family members stated that "I don't know, I don't work here" or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Person A.

Person A was the wife of Patient BE. She said *"Anytime a patient or patient's relative approached the Registrant with a question, such as when they were due for an X-Ray the Registrant would say "I don't know, I don't work here". I found this to be alarming".*

The panel took into account Person A's lengthy detailed statement. The panel was of the view that it is more likely than not that Mrs Ekadi stated that "I don't know, I don't work here" or words to that effect. The panel therefore found charge 6a(i) proved.

Charge 6a(ii)

Whilst working at Alexandra Hospital, Ward 17 on one or more dates between 4 and 9 December 2018, you:

a. Demonstrated inappropriate/poor communication skills in that you:

ii) responded inappropriately to Patient AM when he refused to eat the meal option;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Colleague G and Person A.

Colleague G said in her statement *"The second complaint raised by Person A concerned the Registrants impatience; Patient AM a new patient on the Ward did not like his dinner and the Registrant snapped at Patient AM and said "well you ordered it". I was not a direct witness to this concern but if it was said, I believe the Registrant's response to this was inadequate".*

The panel also took into account the complaint email from Person A to Colleague G where she refers to the incident.

The panel concluded that Mrs Ekadi had responded inappropriately to Patient AM when he refused to eat the meal option. It therefore found charge 6a(ii) proved.

Charge 6a(iii)

Whilst working at Alexandra Hospital, Ward 17 on one or more dates between 4 and 9 December 2018, you:

a. Demonstrated inappropriate/poor communication skills in that you:

iii) did not offer Patient AM an alternative meal when he informed you he did not want the meal option;

This charge is found not proved.

In reaching this decision, the panel determined that Patient AM was given an alternative meal and it is not clear who offered him that meal. In the circumstances, there is insufficient evidence that Mrs Ekadi did not offer an alternative meal.

Charge 6a(iv)

Whilst working at Alexandra Hospital, Ward 17 on one or more dates between 4 and 9 December 2018, you:

a. Demonstrated inappropriate/poor communication skills in that you:

iv. insisted Patient AM eat the meal option;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Person A. Person A said in her statement *"I remember the Registrant telling the patient that he had to eat it, even after he insisted that it was not ordered by him".*

The panel accepted Person A's account of the incident and concluded that before an alternative meal was brought Mrs Ekadi insisted Patient AM eat the meal option. The panel therefore found charge 6a(iv) proved.

Charge 6b(i)

Whilst working at Alexandra Hospital, Ward 17 on one or more dates between 4 and 9 December 2018, you:

b. In respect of Patient BE you:

i. on one or more occasions, did not administer his Parkinson's medication on or around 12:00 as prescribed;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Person A. In her statement she said *"I always arrived to the Ward at 12:00 to help with Patient BE's lunch, which was the same time as his Parkinson's medications were due. On two occasions, the Registrant had not administered Patient BE's medication on time*."

The panel also took into account the complaint email from Person A to Colleague G where she refers to the incident. *"She never gave my husband his Parkinson's medication on time, and when I reminded her, she gave them to him and said to me "happy now"".*

The panel accepted Person A's account of the incident and concluded that Mrs Ekadi did not administer Patient BE's Parkinson's medication on time on one or more occasions. It therefore found charge 6b(i) proved.

Charge 6b(ii)

Whilst working at Alexandra Hospital, Ward 17 on one or more dates between 4 and 9 December 2018, you:

b. In respect of Patient BE you:

ii. placed six tablets in his mouth with water causing him to choke/almost choke;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Person A. Person A said in her statement *"Patient BE told me that the Registrant had put six tablets in his mouth with water at once and that he nearly choked"*. The panel also noted the complaint email from Person A to Colleague G *"My husband on occasion needed 6 tablets at a time. And he said she would put them all into his mouth at the same time and he would nearly choke".*

When challenged about this by Person A, it seems that Mrs Ekadi did not deny doing this, responding *"well he has to have his tablets".*

The panel also had sight of the MAR chart which shows that Patient BE that he should have been administered about six tablets at 12:00.

The panel considered that although Person A was not a direct witness to the incident, it was satisfied with her evidence and concluded that Mrs Ekadi did place six tablets in Patient BE's mouth and found charge 6b(ii) proved.

Charge 6b(iii)

Whilst working at Alexandra Hospital, Ward 17 on one or more dates between 4 and 9 December 2018, you:

b. In respect of Patient BE you:

iii. when questioned about your actions by Person A you said "well he has to have his tablets" or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Person A. Person A said in her statement *"I confronted the Registrant about my concern immediately and asked her to be careful because he could choke. The registrant said 'well he has to have his tablets'".*

The panel considered that although Person A was not a direct witness to the incident, it was satisfied with her evidence and concluded that Mrs Ekadi when questioned about her actions had said *"well he has to have his tablets" or words to that effect.* It therefore found charge 6b(iii) proved.

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 Mrs Ekadi'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 suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

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

Decision on misconduct

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

The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

> ***"1 Treat people as individuals and uphold their dignity (charges 1b, 2, 3, 5, and 6)***
>
> *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*
>
> *1.5. respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns (charges 1b, 5 and 6a)***
>
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***3 Make sure that people's physical, social and psychological needs are***

addressed and responded to (charges 1-6)

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

4 Act in the best interests of people at all times

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

6 Always practise in line with the best available evidence

6.2 maintain the knowledge and skills you need for safe and effective practice

13 Recognise and work within the limits of your competence (charges 1, 3, 4, 5 and 6)

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

16 Act without delay if you believe that there is a risk to patient safety or public protection (charges 1a and 3h)

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice (charges 1-6)

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

20 Uphold the reputation of your profession at all times (charges 1-6)

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

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

In relation to charge 1, the panel considered that Mrs Ekadi's conduct put vulnerable patient's safety at risk, but also displayed a total lack of care, kindness and dignity. Mrs Ekadi failed to take action when an adverse NEWS score required her to escalate to a doctor. Mrs Ekadi treated patients in a way which took advantage of their vulnerability and fell far short of what would have been expected of a registered nurse. Calling a patient "a baby" and stating "if they act like toddlers then that is how they should be treated" and inappropriately handling and restraining patients would be seen as deplorable by fellow practitioners and would damage the trust that the public places in the profession. In the panel's view, Mrs Ekadi's conduct in charge 1 was serious and fell far short of the standards expected of a registered nurse and amounted to misconduct.

In relation to charge 3, the panel noted that Mrs Ekadi had been specifically employed to provide one to one care for the patient which she failed to do as she did not sit by his bedside. It considered that Mrs Ekadi's clinical failings were a significant departure from the principles of proper observational practice and good medication management and administration and put a vulnerable patient's safety at significant risk of harm. Mrs Ekadi's conduct would be seen as deplorable by fellow practitioners and would damage the trust that the public places in the profession. In the panel's view, Mrs Ekadi's conduct in charge 3 was serious and fell far short of the standards expected of a registered nurse and amounted to misconduct.

In relation to charge 4, the panel considered that Mrs Ekadi's clinical failure to administer medication on time was a significant departure from the principles of good medication management and put a vulnerable patient's safety at significant risk of harm. In the panel's view, Mrs Ekadi's omission in charge 4 was serious and fell far below what would be expected of a registered nurse and amounted to misconduct.

In relation to charge 5, the panel considered that Mrs Ekadi's conduct by ignoring a patient's refusal and using unsuitable force to administer medications put patients at risk of harm, would be seen as deplorable by fellow practitioners and would damage the trust that the public places in the profession. Mrs Ekadi also chose to ignore patients' wishes

regarding medication administration. In the panel's view, Mrs Ekadi's conduct in charge 5 was serious and fell far below what would be expected of a registered nurse and amounted to misconduct.

In relation to charge 6, the panel considered that Mrs Ekadi's clinical failings were a significant departure from the principles of good medication management and administration put vulnerable patients' safety at significant risk of harm. Mrs Ekadi also showed poor communication skills in responding to the patients' and families' concerns compassionately and politely. She chose to ignore patients' wishes about meal options and was unhelpful to patients/family members by responding "I don't know, I don't work here" when asked a question. In the panel's view, Mrs Ekadi's conduct in charge 6 was serious and fell far below what would be expected of a registered nurse and amounted to misconduct

The panel determined that Mrs Ekadi's conduct detailed in charges 1-6 fell far short of what would have been expected of a registered nurse. Mrs Ekadi's clinical failings and significant departure from the principles of good medication management and administration put vulnerable patients' safety at significant risk of harm. Mrs Ekadi's conduct would be seen as deplorable by fellow practitioners and would damage the trust that the public places in the profession. Acting with care and keeping patients safe are integral to the standards expected of a registered nurse and central to the Code. Mrs Ekadi's omissions fell far below what would be expected of a registered nurse and a finding of misconduct must follow.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Ekadi's fitness to practise is currently impaired.

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

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in 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" 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 found limbs a, b and c engaged in the *Grant* test. The conduct in question relates to patient care and also Mrs Ekadi's attitudinal problems. Mrs Ekadi's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The charges found proved are wide ranging and involve 13

different patients which Mrs Ekadi placed at unwarranted risk of harm either through clinical failings, medication errors, forcing medication and inappropriate and insensitive communication and treatment. Mrs Ekadi's conduct and failing have put patients at unwarranted risk of harm and indeed are likely to cause future risk to patients.

Regarding insight, the panel considered that Mrs Ekadi has not engaged with the NMC and her responses to date demonstrate no insight, remorse or remediation. The panel noted that there is no evidence to show that Mrs Ekadi has undertaken any further training in relation to safe practice to address her clinical failings, nor has she submitted any reflective piece in regard to her conduct in general since October/November 2018. Furthermore, Mrs Ekadi has expressed very negative thoughts towards the profession.

In an email to the NMC dated 15 February 2020, Mrs Ekadi stated *"I now hate the profession with my every being and do not which (sic) to be associated with it anymore. Please struck (sic) me out of your register."*

In a more recent email dated 3 June 2021, Mrs Ekadi stated *"Also I do not wish to continue with the case anymore. I have demanded to be strucked (sic) off the register. I have moved on!, and not available to attend any meeting. Please do not communicate with me about this issue anymore. I am not practising Nursing and Midwifery anymore and do not have any obligation to NMC anymore. I will be fine with whatever decision you make".*

The panel was satisfied that the misconduct in this case is capable of remediation but in light of the above, it took account of the fact that Mrs Ekadi was unlikely to do so. The panel took into account that there is no evidence that the concerns in this case have been remediated. The panel is of the view that there is a risk of repetition based on Mrs Ekadi's lack of insight, remediation and remorse. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that 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 concluded that public confidence

in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Ekadi's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the Registrar to strike Mrs Ekadi off the register. The effect of this order is that the NMC register will show that Mrs Ekadi has been struck-off the register.

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

Decision and reasons on sanction

Having found Mrs Ekadi'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.

The panel took into account the following aggravating features:

- Mrs Ekadi's misconduct put patients at risk of harm.
- The patients involved were either; high risk patients, vulnerable, and/or lacked capacity.

- Mrs Ekadi's misconduct related to multiple, fundamental nursing skills covering four different employers, over a period of some months.
- Mrs Ekadi has demonstrated attitudinal issues.
- Mrs Ekadi has shown no insight, remediation or remorse for her misconduct.
- Mrs Ekadi has not engaged with the NMC proceedings.

The panel also took into account the following mitigating features:

- Mrs Ekadi refers to periods of stress.
- In the majority of the placements Mrs Ekadi was a new agency nurse and unfamiliar with procedures and policies.

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 not protect the public nor be 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 Mrs Ekadi's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Ekadi's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Ekadi's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the wide ranging nature of the charges in this case. The panel noted that Mrs Ekadi has demonstrated that she is unwilling to address the issues raised and does not want to continue nursing. Furthermore, the panel concluded that the placing of conditions on Mrs

Ekadi's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel considered that misconduct identified related to fundamental nursing skills involving multiple patients, family member and colleagues. The misconduct also covered four different employers, over a period of some months. Mrs Ekadi has demonstrated a complete absence of any insight or remediation into her failings and has stated that she no longer wishes to practice as a nurse. The panel was of the view that Mrs Ekadi has demonstrated attitudinal concerns in her limited responses to the NMC and also in her lack of engagement with the proceedings. Mrs Ekadi has demonstrated a pattern of failings in her practice and behaviour, and in the absence of any insight, remediation or remorse it is the panel's view that she poses a significant risk of repeating her conduct.

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

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

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

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

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

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

The panel considered that this order was necessary to protect patients and mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This decision will be confirmed to Mrs Ekadi in writing.

Interim order

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

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period.

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

That concludes this determination.