# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**13 – 16 July 2021**

**Virtual Hearing**

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|---|---|
| **Name of registrant:** | **Emily Nolamla Ntsikizana** |
| **NMC PIN:** | 00E1124O |
| **Part(s) of the register:** | Registered Nurse – Sub Part 1<br>RN1: Adult Nurse – 24 January 2000 |
| **Area of registered address:** | Hampshire |
| **Type of case:** | Misconduct |
| **Panel members:** | John Penhale (Chair, Lay member)<br>Allwin Mercer (Registrant member)<br>Suzy Ashworth (Lay member) |
| **Legal Assessor:** | Clare Bates |
| **Panel Secretary:** | Sherica Dosunmu |
| **Nursing and Midwifery Council:** | Represented by Alys Williams, Case Presenter |
| **Miss Ntsikizana:** | Not in attendance and not represented |
| **Facts proved:** | Charges 1, 2a, 2b, 2e, 2f, 3c, 5a, 5d, 5e, 6a, 6b, 7a, 7b |
| **Facts not proved:** | Charges 2c, 2d, 3a, 3b, 4, 5b, 5c |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Suspension order (6 months)** |
| **Interim order:** | **Interim suspension order (18 months)** |

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Miss Ntsikizana was not in attendance and that the Notice of Hearing had been sent to Miss Ntsikizana by email on 11 June 2021. Ms Williams, on behalf of the Nursing and Midwifery Council (NMC), referred the panel to a witness statement signed by a NMC Case Coordinator confirming this had been sent.

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

Ms Williams, 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). She stated that Rule 34 (c) indicates that service can be provided through electronic means.

The panel accepted the advice of the legal assessor.

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

The panel noted that the Rules do not require evidence of receipt of the notice and that it is the responsibility of any registrant to maintain an effective and up-to-date contact information.

**Decision and reasons on proceeding in the absence of Miss Ntsikizana**

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

Ms Williams submitted that there had been no engagement at all by Miss Ntsikizana with the NMC in relation to these proceedings. She submitted that there was no request from Miss Ntsikizana for the hearing to be adjourned and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion.

Ms Williams referred the panel to various attempts by the NMC to contact Miss Ntsikizana on a variety of dates and submitted that there had been no response from Miss Ntsikizana to emails or an attempted telephone call from the NMC.

Ms Williams informed the panel that a letter was also posted to Miss Ntsikizana's registered address on 5 November 2019 and this post was returned to the NMC. She submitted that it is Miss Ntsikizana's duty to update the NMC with any change to her address and this was not done.

Ms Williams submitted that the NMC had made efforts to trace Miss Ntsikizana both in the UK and abroad, but with no success.

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 has decided to proceed in the absence of Miss Ntsikizana. In reaching this decision, the panel has considered the oral submissions of Ms Williams, and the advice of the legal assessor. It has had particular regard to the factors set out in the decisions 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 took into account that:

- No application for an adjournment has been made by Miss Ntsikizana;
- Miss Ntsikizana has not engaged with the NMC and has not responded to any emails or an attempt to call her about this hearing;
- Miss Ntsikizana has not provided the NMC with details of how she may be contacted other than her registered address;
- Miss Ntsikizana is now untraceable, which appears to be voluntary and deliberate;
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Miss Ntsikizana in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address and email, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give 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 Ntsikizana's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

**Details of charge (as amended)**

That you a registered nurse:

1. On 7 August 2019, incorrectly recorded Resident A's blood glucose readings in Resident B's Daily Blood Glucose Testing Record Sheet. **[FOUND PROVED]**

2. On 10 August 2019, did not offer fluids and/or in the alternative did not complete the fluid balance charts for:
    a. Resident C **[FOUND PROVED]**
    b. Resident D **[FOUND PROVED]**
    c. Resident E **[FOUND NOT PROVED]**
    d. Resident F **[FOUND NOT PROVED]**
    e. Resident G **[FOUND PROVED]**
    f. Resident H **[FOUND PROVED]**

3. On 16 August 2019, on or before 04:00am, you:
    a. Inaccurately pre-recorded in the Resident Monitor/Review Record that Resident D was asleep at 04.00 when he was “awake and shouting”. **[FOUND NOT PROVED]**
    b. Inaccurately pre-recorded in the Resident Monitor/Review Record that Resident D had received a drink at 06.30am. **[FOUND NOT PROVED]**
    c. Pre-recorded in the Resident Monitor/Review Record inaccurate depictions of a number of unknown residents from 04:00-06:30. **[FOUND PROVED]**

4. Your actions as set out in charges in 3a-3c were dishonest as you knew the depictions of the residents and/or the care given was not as described. **[FOUND NOT PROVED]**

5. On 18 August 2019, upon Resident I sustaining a head injury you:
    a. Did not contact the GP. **[FOUND PROVED]**
    b. Did not carry out any observations over a 12- 24 hour period. **[FOUND NOT PROVED]**
    c. Did not record any observations on Resident I. **[FOUND NOT PROVED]**
    d. Did not administer paracetamol and/or failed to record the administration in the MAR chart. **[FOUND PROVED]**
    e. Did not contact Resident I’s family. **[FOUND PROVED]**

6. On or around 18 August 2019, inaccurately recorded in an Accident form that you:
    a. Administered paracetamol to Resident I. **[FOUND PROVED]**
    b. Contacted the family of Resident I. **[FOUND PROVED]**

7. Your actions as set out in charges 6a and/or 6b were dishonest in that, you:
    a. Knew you had not administered paracetamol to Resident I. **[FOUND PROVED]**
    b. Attempted to create a misleading picture of the care you provided. **[FOUND PROVED]**

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

**Decision and reasons on application to amend charges**

The panel heard an application made by Ms Williams, to amend the wording of charges 1 and 3 a, b, c.

The proposed amendments were to change the wording in charge 1 from '*MAR chart*' to '*Daily Blood Glucose Testing Record Sheet*' and the wording in charge 3 a, b, c from '*MAR chart*' to '*Resident Monitor/Review Record*'. It was submitted by Ms Williams that the proposed amendments would more accurately reflect the evidence, as Ms 1 clarified in her oral evidence that there were errors with the name of these exhibits in her witness statements. She submitted that such amendments would be technical amendments and would not cause any unfairness as they did not alter the overall substance of the charges.

<u>Original charges:</u>

1. On 7 August 2019, incorrectly recorded Resident A's blood glucose readings in Resident B's MAR chart.

3. On 16 August 2019, on or before 04:00am, you:
a. Inaccurately pre-recorded in the MAR chart that Resident D was asleep at 04.00 when he was “awake and shouting”.
b. Inaccurately pre-recorded in the MAR chart that Resident D had received a drink at 06.30am.
c. Pre-recorded in the MAR charts inaccurate depictions of a number of unknown residents from 04:00-06:30.

Proposed charges:

1. On 7 August 2019, incorrectly recorded Resident A’s blood glucose readings in Resident B’s **Daily Blood Glucose Testing Record Sheet** ~~MAR chart~~.

3. On 16 August 2019, on or before 04:00am, you:
a. Inaccurately pre-recorded in the **Resident Monitor/Review Record** ~~MAR chart~~ that Resident D was asleep at 04.00 when he was “awake and shouting”.
b. Inaccurately pre-recorded in the **Resident Monitor/Review Record** ~~MAR chart~~ that Resident D had received a drink at 06.30am.
c. Pre-recorded in the **Resident Monitor/Review Record** ~~MAR charts~~ inaccurate depictions of a number of unknown residents from 04:00-06:30.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Miss Ntsikizana and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

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

During the course of the evidence of Ms 1 it became apparent that some of the evidence touched on matters relating to Miss Ntsikizana’s health.

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

Having heard that there may be reference to Miss Ntsikizana's health, the panel determined to hold such parts of the hearing in private.

**Background**

The NMC received a referral on 7 October 2019 from Miss Ntsikizana's former employer, Milkwood Care Ltd, in relation to concerns raised while Miss Ntsikizana was working at Chatterwood Nursing Home (the Home) in Hampshire. Miss Ntsikizana began working at the Home on 9 September 2006 as a registered nurse.

The referral alleges that Miss Ntsikizana made a number of clinical errors while working at the Home in August 2019. These included:

- On 7 August 2019, Miss Ntsikizana recorded the daily blood glucose information for Resident A in Resident B's chart, and as a result, both charts were inaccurate.
- On 10 August 2018, Miss Ntsikizana failed to complete fluid charts for residents at the Home.
- On 16 August 2018, Miss Ntsikizana completed observation and turning charts for residents before they were due to be completed.
- On 18 August 2018, Miss Ntsikizana did not conduct observations on Resident I who had previously had a fall, and failed to record that paracetamol had been administered to Resident I. Miss Ntsikizana also recorded that she informed Resident I's family of the fall, but did not.

Miss Ntsikizana was suspended by the Home on 29 August 2019 while a full investigation into the concerns were carried out.

On 5 September 2019, Miss Ntsikizana was invited to attend a disciplinary hearing. She did not attend. On 25 September 2019, Miss Ntsikizana sent a letter to the Home manger in which she resigned from her position at the Home.

**Decision and reasons on facts**

In reaching its decisions on the facts, the panel considered all the evidence adduced in this case together with the submissions made by Ms Williams, on behalf of the NMC.

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

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:

- Ms 1: Registered Manager at the Home;
- Dr 2: Daughter of Resident I;
- Mr 3: Son-in-law of Resident I.

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.

The panel considered the evidence of the witnesses and made the following conclusions:

Ms 1, Registered Manager: The panel considered that Ms 1 was a credible and reliable witness. The panel considered that Ms 1 gave direct and helpful evidence and was clear

where she was unable to recall specific matters or answer specific questions. The panel is satisfied that the meeting notes produced by Ms 1 are accurate and true records of the meetings held with Miss Ntsikizana about her performance. The panel noted there was some confusion in Ms 1's oral evidence about which residents the relevant charts belong to. The panel determined that Ms 1's evidence was not assisted by redactions. The panel was of the view that this did not fundamentally affect the overall credibility of her evidence.

Dr 2, Daughter of Resident I: The panel considered the evidence of Dr 2 to be credible and reliable and consistent with her written statement.

Mr 3, Son-in-law of Resident I: The panel considered the evidence of Mr 3 to be credible and reliable and consistent with his written statement.

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

**Charge 1**

1. On 7 August 2019, incorrectly recorded Resident A's blood glucose readings in Resident B's Daily Blood Glucose Testing Record Sheet.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1. The panel considered that there was sufficient evidence available in Ms 1's oral evidence supported by documentary evidence to make a finding that Miss Ntsikizana made a recording error.

The panel observed that Miss Ntsikizana was given the opportunity to address this allegation on two separate occasions, a meeting with Ms 1 held on 15 August 2019 and another meeting held with Ms 1 on 23 August 2019. The panel noted that on both occasions Miss Ntsikizana accepted that she made a mistake. In the meeting notes

form 15 August 2019, it is recorded that in response to being asked about the recording error, Miss Ntsikizana replied:

> *"… it must have just been an oversight".*

In the meeting notes form 23 August 2019, it is recorded that in response to being asked about the recording error, Miss Ntsikizana replied:

> *"My explanation for this is that I have been doing too much and I was tired and I lost [concentration] as I was tired."*

The panel concluded that there was mutually corroborative and credible evidence to determine that Miss Ntsikizana incorrectly recorded Resident A's blood glucose readings in Resident B's Daily Blood Glucose Testing Record Sheet.

Consequently, the panel found charge 1 proved.

**Charge 2a**

2. On 10 August 2019, did not offer fluids and/or in the alternative did not complete the fluid balance charts for:

a. Resident C

**This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence given by Ms 1 and the documentary evidence from the fluid balance chart for Resident C.

The panel was of the view that Ms 1's oral evidence made sufficiently clear the expectation and duty of a nurse to offer fluids to the residents in the Home. It was therefore satisfied that Miss Ntsikizana should have offered fluid and completed the fluid balance chart.

The panel noted that there was no entry in Resident C's fluid balance chart for the period during which Miss Ntsikizana was the nurse in charge on 10 August 2019.

The panel found that it had not received any evidence that Miss Ntsikizana had or had not offered fluids. In the absence of any further evidence, the panel was satisfied that the fluid balance chart supported a finding that no entry had been made.

Accordingly, charge 2a was found proved.

**Charge 2b**

2. On 10 August 2019, did not offer fluids and/or in the alternative did not complete the fluid balance charts for:

b. Resident D

**This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence given by Ms 1 and the documentary evidence from the fluid balance chart for Resident D.

The panel was of the view that Ms 1's oral evidence made sufficiently clear the expectation and duty of a nurse to offer fluids to the residents in the Home. It was therefore satisfied that Miss Ntsikizana should have offered fluid and completed the fluid balance chart.

The panel noted that there was no entry in Resident D's fluid balance chart for the period during which Miss Ntsikizana was the nurse in charge on 10 August 2019.

The panel found that it had not received any evidence that Miss Ntsikizana had or had not offered fluids. In the absence of any further evidence, the panel was satisfied that the fluid balance chart supported a finding that no entry had been made.

Accordingly, charge 2b was found proved.

**Charge 2c**

2. On 10 August 2019, did not offer fluids and/or in the alternative did not complete the fluid balance charts for:

c. Resident E

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the documentary evidence from the fluid balance chart for Resident E.

The panel observed that the fluid charts for Resident E recorded fluids being given at 6:00am.

Accordingly, the panel found charge 2c not proved.

**Charge 2d**

2. On 10 August 2019, did not offer fluids and/or in the alternative did not complete the fluid balance charts for:

d. Resident F

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the documentary evidence from the fluid balance chart for Resident F.

The panel observed that the fluid charts exhibited for Resident F recorded fluids being given at 5:00am.

Accordingly, the panel found charge 2d not proved.

**Charge 2e**

2. On 10 August 2019, did not offer fluids and/or in the alternative did not complete the fluid balance charts for:

e. Resident G

**This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence given by Ms 1 and the documentary evidence from the fluid balance chart for Resident G.

The panel was of the view that Ms 1's oral evidence made sufficiently clear the expectation and duty of a nurse to offer fluids to the residents in the Home. It was therefore satisfied that Miss Ntsikizana should have offered fluid and completed the fluid balance chart.

The panel noted that there was no entry in Resident G's fluid balance chart for the period during which Miss Ntsikizana was the nurse in charge on 10 August 2019.

The panel found that it had not received any evidence that Miss Ntsikizana had or had not offered fluids. In the absence of any further evidence, the panel was satisfied that the fluid balance chart supported a finding that no entry had been made.

Accordingly, charge 2e was found proved.

**Charge 2f**

2. On 10 August 2019, did not offer fluids and/or in the alternative did not complete the fluid balance charts for:

f. Resident H

**This charge is found proved.**

In reaching this decision, the panel took into account the oral evidence given by Ms 1 and the documentary evidence from the fluid balance chart for Resident H.

The panel was of the view that Ms 1's oral evidence made sufficiently clear the expectation and duty of a nurse to offer fluids to the residents in the Home. It was therefore satisfied that Miss Ntsikizana should have offered fluid and completed the fluid balance chart.

The panel noted that there was no entry in Resident H's fluid balance chart for the period during which Miss Ntsikizana was the nurse in charge on 10 August 2019.

The panel found that it had not received any evidence that Miss Ntsikizana had or had not offered fluids. In the absence of any further evidence, the panel was satisfied that the fluid balance chart supported a finding that no entry had been made.

Accordingly, charge 2f was found proved.

**Charge 3a**

3. On 16 August 2019, on or before 04:00am, you:

a. Inaccurately pre-recorded in the Resident Monitor/Review Record that Resident D was asleep at 04.00 when he was "awake and shouting".

**This charge is found NOT proved**.

In reaching this decision, the panel took into account the evidence of Ms 1 and the documentary evidence from the Resident Monitor/Review Record for Resident D.

The panel noted that Ms 1's oral evidence could not be corroborated by the documentary evidence, as Ms 1 expressed some confusion about whether the Resident Monitor/Review Record for Resident D belonged to the resident in question.

The panel found that there was not sufficient accurate information to establish that it was more likely than not that Miss Ntsikizana had inaccurately pre-recorded in the Resident Monitor/Review Record that Resident D was asleep at 4:00am when the resident was '*awake and shouting*'.

Accordingly, the panel found charge 3a not proved.

**Charge 3b**

3. On 16 August 2019, on or before 04:00am, you:

    b. Inaccurately pre-recorded in the Resident Monitor/Review Record that Resident D had received a drink at 06.30am.

**This charge is found NOT proved**.

In reaching this decision, the panel took into account the evidence of Ms 1 and the documentary evidence from the Resident Monitor/Review Record for Resident D.

The panel noted that Ms 1 was confused about which record belonged to Resident D, but in none of the relevant records was a drink recorded as having been given at 6:30am.

The panel therefore determined that there has been no evidence to prove that Miss Ntsikizana inaccurately pre-recorded in the Resident Monitor/Review Record that Resident D had received a drink at 06.30am.

Accordingly, the panel found charge 3b not proved.

**Charge 3c**

> 3. On 16 August 2019, on or before 04:00am, you:
>
> c. Pre-recorded in the Resident Monitor/Review Record inaccurate depictions of a number of unknown residents from 04:00-06:30.

**This charge is found proved**.

In reaching this decision, the panel accepted the evidence of Ms 1. The panel considered that the oral evidence of Ms 1 is supported by consistency with her written statement, the Resident Monitor/Review Records exhibited and meeting notes from a meeting with Ms 1 and Miss Ntsikizana on 16 August 2019.

In the meeting notes form 16 August 2019, it is recorded that in response to being asked why the charts were pre-recorded, Miss Ntsikizana replied:

> *"We were short staffed and I just panicked and was worried that we wouldn't have time to complete them."*

The panel determined that Miss Ntsikizana's response provides a clear indication that she accepted that she pre-recorded inaccurate depictions in the Resident Monitor/Review Record.

The panel therefore concluded that there was mutually corroborative and credible evidence to determine that Miss Ntsikizana pre-recorded in the Resident Monitor/Review Record inaccurate depictions.

Consequently, the panel found charge 3c proved.

**Charge 4**

4. Your actions as set out in charges in 3a-3c were dishonest as you knew the depictions of the residents and/or the care given was not as described.

**This charge is found NOT proved.**

In reaching this decision, the panel considered that charge 4 was insufficiently particularised for there to be a finding of dishonesty in relation to 3 a-c. The panel considered that it is a serious matter to make a finding of dishonesty and on a reasonable interpretation of the charge it required the actions at 3 a - c to have been found proved. The panel found the facts of charge 3 a - b not proved.

Accordingly, the panel found charge 4 not proved.

**Charge 5a**

5. On 18 August 2019, upon Resident I sustaining a head injury you:

   a. Did not contact the GP.

**This charge is found proved.**

In reaching this decision, the panel accepted the evidence of Ms 1 as clear and consistent with the three accident forms exhibited. The panel was of the view that it is clearly indicated on all forms that a General Practitioner (GP) was not contacted.

The panel considered the guidance from the Home's post-falls protocol document and found that there is a clear indication that it was Miss Ntsikizana's duty to contact a GP at the time.

The panel was therefore satisfied that the oral and documentary evidence supports a finding that Miss Ntsikizana did not contact the GP.

Accordingly, the panel found charge 5a proved.

**Charge 5b**

5. On 18 August 2019, upon Resident I sustaining a head injury you:

b. Did not carry out any observations over a 12- 24 hour period.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and the guidance in the Home's post-falls protocol document. The panel was satisfied that it was clear that observations should be carried out every four hours. The panel also noted that the post fall observation log requires observations to be completed four hourly over a period of 24-48hrs.

The panel noted that the incident occurred at 4:30am while Miss Ntsikizana was on night shift duty and due to end her shift at 8:30am.

The panel was not satisfied that Miss Ntsikizana was under a duty to carry out any post fall observation over a 12-24 hour period because her shift finished four hours after the incident occurred.

Accordingly, the panel found charge 5b not proved.

**Charge 5c**

5. On 18 August 2019, upon Resident I sustaining a head injury you:

c. Did not record any observations on Resident I.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the documentary evidence from the accident/incident reporting forms exhibited.

The panel considered that in all three accident/incident forms, the section titled 'Baseline Observation' including blood pressure, pulse and oxygen level observations were all documented.

Accordingly, the panel found charge 5c not proved.

**Charge 5d**

5. On 18 August 2019, upon Resident I sustaining a head injury you:

d. Did not administer paracetamol and/or failed to record the administration in the MAR chart.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and the documentary evidence from the accident/incident reporting forms exhibited.

The panel accepted the oral evidence of Ms 1 was consistent with her witness statement and provided a clear account of the checking process carried out in the Home to identify medication administration. The panel considered that in Ms 1's evidence, this medication checking process identified that paracetamol was not given.

The panel noted that on all three accident/incident forms Miss Ntsikizana documented that she had given Resident I paracetamol. This was not recorded on Resident I's MAR chart.

The panel concluded that Ms 1 provided a credible and detailed account and determined it more likely than not that Miss Ntsikizana failed to administer paracetamol.

Consequently, the panel found charge 5d to be proved.

**Charge 5e**

5. On 18 August 2019, upon Resident I sustaining a head injury you:

    e. Did not contact Resident I's family.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1, Dr 2 and Mr 3.

The panel considered that the evidence of all witnesses was consistent in indicating that Resident I's family had not been contacted.

The panel concluded that there was mutually corroborative and credible evidence that Miss Ntsikizana did not contact Resident I's family. The panel therefore found charge 5e proved.

**Charge 6a**

6. On or around 18 August 2019, inaccurately recorded in an Accident form that you:

    a. Administered paracetamol to Resident I.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1 and the documentary evidence from the accident/incident reporting forms exhibited.

The panel accepted the oral evidence of Ms 1 as consistent with her witness statement and provided a clear account of the checking process carried out in the Home to identify medication administration. The panel considered that in Ms 1's evidence, this medication checking process identified that paracetamol was not given.

The panel noted that on all three accident/incident forms Miss Ntsikizana documented that she had given Resident I paracetamol. This was not recorded on Resident I's MAR chart.

The panel therefore concluded that the accident report forms provided evidence that Miss Ntsikizana inaccurately recorded that she had administered paracetamol to Resident I.

Consequently, the panel found charge 6a to be proved.

**Charge 6b**

6. On or around 18 August 2019, inaccurately recorded in an Accident form that you:

b. Contacted the family of Resident I.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1, Dr 2 and Mr 3.

The panel noted that Miss Ntsikizana recorded in her first accident form that she had contacted Resident I's family. The panel considered that the oral evidence of all witnesses were consistent in indicating that Resident I's family had not been contacted.

The panel concluded that there was mutually corroborative and credible evidence that Resident I's family was not contacted and Miss Ntsikizana recorded that she had done so. The panel therefore found charge 6b proved.

**Charge 7**

7. Your actions as set out in charges 6a and/or 6b were dishonest in that, you:

a. Knew you had not administered paracetamol to Resident I.
b. Attempted to create a misleading picture of the care you provided.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Ms 1, Dr 2 and Mr 3.

The panel reminded itself that it had found proved charges 6a and b. In applying the legal test for dishonesty and referring to the case of *Ivey v Genting Casinos* [2017] UKSC 67, the panel found that when Miss Ntsikizana wrote the accident report, she was aware that she had neither administered paracetamol to Resident I nor had informed the family of Resident I about the incident, and in the circumstances the panel considered this to be dishonest.

The panel considered whether there was any evidence of an alternative explanation but concluded there was not.

The panel therefore found charge 7 a and b proved.

**Additional legal advice**

The panel received legal advice in private, which was repeated in public.

The panel asked for legal advice on charge 4, which alleged that the actions of Miss Ntsikizana as set out in charges 3a-3c were dishonest as she knew the depictions of the residents and/or the care given was not as described.

The legal assessor advised that in light of the findings that charges 3a and 3b had not been proved, when considering this charge, the panel should apply their own common sense and judgement and consider whether all three elements of charge 3 are required for a finding of dishonesty. She referred the panel to the case of *Fish v General Medical Council [2012] EWHC 1269 (Admin)* and *Shala and Abushkeika v GMC Privy Council 32/2003 and 35/2003*. She advised the panel that a fundamental principle of fairness requires a charge of dishonesty to be unambiguously formulated and adequately particularised.

**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 Ntsikizana'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, Miss Ntsikizana's fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

Ms Williams invited the panel to take the view that the facts found proved amount to misconduct. She directed the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ('the Code') in making its decision. Ms Williams outlined specific standards of the Code, which she submitted have been breached.

Ms Williams submitted that Miss Ntsikizana's failings in her clinical practice included, putting residents at real risk of harm, inaccurate record keeping, failure to administer medication where appropriate, failure to refer to GP where appropriate, and dishonesty.

Ms Williams submitted whilst it is accepted that breaches of the Code will not be conclusive as to the issue of misconduct, Miss Ntsikizana's failings involve wide ranging fundamental requirements for the nursing profession. She submitted that Miss Ntsikizana's actions do fall seriously short of the conduct and standards expected of a nurse and amounts to misconduct.

**Submissions on impairment**

Ms Williams 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 *CHRE v Grant & NMC [2011] EWHC 927 (Admin).*

Ms Williams submitted that Miss Ntsikizana failed to properly address the needs of residents with appropriate attention or skill on four separate occasions. She submitted that inadequate record keeping is consistent through almost all charges and puts patients at unwarranted risk of serious harm. She submitted that Miss Ntsikizana's failure to adequately escalate Resident I's fall also caused unwarranted risk of serious harm.

Ms Williams submitted that Miss Ntsikizana has not engaged with the NMC, so there is no evidence to suggest her actions have been remediated. She submitted that as a result, Miss Ntsikizana is liable in future to put patients at unwarranted risk of harm.

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *Calheam v GMC [2007] EWHC 2606 (Admin).*

**Decision and reasons on misconduct**

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

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

> ***'Treat people as individuals and uphold their dignity***
> *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*
>
> ***Make sure that people's physical, social and psychological needs are assessed and responded to***
> *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*

***Work cooperatively***

*8.6 share information to identify and reduce risk*

***10 Keep clear and accurate records relevant to your practice***

*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*

*10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

*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*

***Recognise and work within the limits of your competence***

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

***14 Be open and candid with all service users about all aspects of care and treatment including when any mistakes or harm have taken place***

*14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm*

*14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

*14.3 document all these events formally and take further action (escalate) if appropriate*

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

*18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health*

***20 uphold the reputation of your profession at all times***
*20.1 keep to and uphold the standards and values set out in the Code*
*20.2 act with honesty and integrity at all times'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Miss Ntsikizana's failures were serious, wide ranging and involved dishonesty.

The panel considered that looking at some of the charges individually, they may have not reached the threshold to constitute serious misconduct alone. The panel was of the view that, in this case, charges 1 and 2 in isolation would be regarded as poor practice rather than misconduct.

In relation to charge 3c found proved, the panel reminded itself that the charge related to falsifying records. The panel considered that Miss Ntsikizana's failure to record accurately could have had clinical implications and was in breach of standards 1.2, 10.1, 10.3, 20 and 20.1 of the Code.

The panel next considered charges 5a, 5d, 5e, found proved. The panel reminded itself that Miss Ntsikizana failed to contact a GP in relation to Resident I's fall and failed to follow protocol and provide adequate care to Resident I. The panel considered that Resident I was put at risk of significant harm as a result of Miss Ntsikizana's actions and omissions. The panel was of the view that Miss Ntsikizana's actions in charges 5a, 5d, 5e were in breach of standards 1.2, 1.4, 3.1, 8.6, 13.2, 14.2, 18.1 of the Code.

The panel next considered charge 6a and 6b found proved. The panel was of the view that Resident I's concerns were exacerbated by Miss Ntsikizana's dishonesty in falsifying that she had administered paracetamol when she had not and recording that she had contacted Resident I's family when she had not. The panel was of the view that

Miss Ntsikizana's actions in charges 6a and 6b were in breach of standards 1.2, 10, 10.3 of the Code.

The panel also had regard to charges 7a and 7b in relation to dishonesty and a lack of integrity. The panel noted that dishonesty doesn't always amount to misconduct but in this circumstance the panel considered Miss Ntsikizana's actions particularly serious. The panel considered that when Miss Ntsikizana wrote the accident report, she was aware that she did not administer paracetamol to Resident I and had not informed the family of Resident I about the incident. The panel considered that honesty and integrity are the bedrocks of the nursing profession and Miss Ntsikizana was in breach of standards 10.3, 14.1, 14.2, 14.3, 20, 20.1, 20.2 of the Code.

The panel therefore found that Miss Ntsikizana's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

The panel next went on to decide if as a result of the misconduct, Miss Ntsikizana'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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered this test and found that all four limbs were engaged in this case. The panel finds that patients were put at risk and could have been caused physical and emotional harm as a result of Miss Ntsikizana's misconduct. Miss Ntsikizana's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the

nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel had no evidence of Miss Ntsikizana's current level of insight regarding her misconduct.

The panel was satisfied that the misconduct in this case is capable of remediation, although it noted that the misconduct also relates to dishonesty, which is difficult to remediate. Therefore, the panel carefully considered the evidence before it in determining whether or not Miss Ntsikizana has remedied her practice. However the panel determined that there was no evidence to indicate remediation.

The panel is of the view that due to the lack of insight or evidence of remediation there remains a real risk of repetition of the concerns raised. The panel noted that Miss Ntsikizana failed to perform a number of key nursing duties as the nurse in August 2019 and considered that there is a real risk of harm to the public if Miss Ntsikizana was allowed to practise without restriction. 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.

In addition, 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 Miss Ntsikizana's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Ntsikizana's fitness to practise is currently impaired on the grounds of both public protection and public interest.

**Sanction**

The panel has considered this case very carefully and has decided to make a suspension order for a period of 6 months. The effect of this order is that the NMC register will show that Miss Ntsikizana's registration has been suspended.

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.

**Submissions on sanction**

Ms Williams informed the panel that in the Notice of Hearing, dated 11 June 2021, the NMC had advised Miss Ntsikizana that it would seek the imposition of a suspension order for a period 12 months if it found Miss Ntsikizana's fitness to practise currently impaired.

Ms Williams referred the panel to the SG and submitted that the aggravating factors in this case include:

- Elements of dishonesty
- Lack of evidence of insight, lack of remediation and lack of engagement
- Repeated failings relating to basic clinical practice

Ms Williams then moved onto the mitigating factors in this case, which she submitted to be:

- Limited admissions
- Some less serious charges
- The dishonesty being an isolated event

Ms Williams submitted that making no order or imposing a caution order would not be appropriate. She submitted that while some charges did involve misconduct at the lower

end of the spectrum in terms of seriousness, there has been a range of failings that has placed patients at significant risk of harm and also included a finding of dishonesty.

Ms Williams submitted that some of the errors made by Miss Ntsikizana in this case are remediable, however, Miss Ntsikizana would need significant supervision and given the lack of information about Miss Ntsikizana's current employment and circumstances, workable conditions could not be formulated. Additionally, she submitted that considering the finding of dishonesty, lack of evidence of insight and lack of remediation, a conditions of practice order would not be sufficient.

Ms Williams invited the panel to impose a suspension order for a period of 12 months. She submitted that Miss Ntsikizana's temporary removal from the register will adequately address the public protection and public interest considerations of this case.

The panel accepted the advice of the legal assessor, who referred it to the case of *Rashid v GMC [2007] 1WLR 1460.*

**Decision and reasons on sanction**

Having found Miss Ntsikizana'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 that the findings of misconduct in this case relate to events which occurred in August 2019. On 16 August 2019 Miss Ntsikizana had pre-recorded inaccurate depictions of the care given to a number of residents. On 18 August she had failed to contact the GP or administer paracetamol when a resident sustained a head injury. The panel noted that she also failed to contact the Resident I's family and inaccurately completed an Accident form to create the picture that she had both given paracetamol and contacted the family.

The panel took into account the following aggravating features:

- Miss Ntsikizana was dishonest
- Miss Ntsikizana has not provided any evidence of remediation
- Miss Ntsikizana has not provided the panel with any evidence of insight into her failings
- Miss Ntsikizana's actions created a risk of harm to the residents in her care.

The panel also took into account the following mitigating features:

- The panel heard from Ms 1 that Miss Ntsikizana had previously been a good nurse. The panel accepted she was of previous good character and had no history of regulatory concerns.

The panel then assessed the dishonesty in this case, and its level of seriousness. The panel considered that dishonesty is always serious, and it bore in mind that when Miss Ntsikizana wrote the accident report, she was aware that she did not administer paracetamol to Resident I and had not informed the family of Resident I about the incident, but stated that she done so.

The panel had regard to the NMC's guidance on considering sanctions for serious cases, and in particular for cases involving dishonesty. This guidance sets out factors which may be apparent in more serious and less serious cases involving dishonesty. Specifically, it states that:

*'…Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*

- *Deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
- *Misuse of power*
- *Vulnerable victims*

- *Personal financial gain from a breach of trust*
- *Direct risk to patients*
- *Premeditated, systematic or longstanding deception*

*Dishonest conduct will generally be less serious in cases of:*

- *One-off incidents*
- *Opportunistic or spontaneous conduct*
- *No direct personal gain*
- *No risk to patients*
- *Incidents in private life of nurse, midwife or nursing associate.'*

The panel considered that Miss Ntsikizana's dishonesty did involve deliberately breaching the duty of candour by covering up that she did not follow the Home's protocol to provide appropriate level of care to Resident I. The panel also considered that her actions did involve a degree of risk to the resident as she did not administer paracetamol, albeit the panel acknowledged that there was no evidence that this resident did suffer harm.

The panel considered that Miss Ntsikizana's dishonesty was a one-off incident, with no evidence of such behaviour having been repeated. The panel did not consider that her actions were evidence of a premeditated, systematic or longstanding deception. Furthermore, it also considered there was no direct personal gain to Miss Ntsikizana's as a result of her dishonesty.

Having regard to these factors, and the circumstances in which the dishonesty occurred, the panel considered that whilst it was serious, it was not at the highest end of the spectrum of dishonest behaviour.

The panel then went on to consider what action, if any, to take in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the finding of dishonesty and the risk to patient safety identified.

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 a caution order would not adequately protect the public nor address the public interest as it would not mark the seriousness of the case. The panel decided that it would be neither appropriate nor proportionate to impose a caution order.

The panel next considered whether placing conditions of practice on Miss Ntsikizana's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG and concluded that there are no practical or workable conditions that could be formulated. The misconduct identified only partially relates to Miss Ntsikizana's clinical practice and included concerns relating to dishonesty. The panel noted that it had not been provided with any information regarding Miss Ntsikizana's current circumstances and in particular whether she is currently working. The panel did not receive any evidence of remediation or insight and was not aware if Miss Ntsikizana would be willing to submit to and comply with conditions. In these circumstances the panel concluded that workable conditions could not be formulated, which would adequately protect the public and mark public interest.

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 panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Miss Ntsikizana's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. The panel concluded that a suspension order would be appropriate and would allow Miss Ntsikizana the opportunity to engage with the NMC and show evidence of her remediation and insight.

The panel noted the hardship such an order will inevitably cause Miss Ntsikizana. However this is outweighed by the public interest in this case.

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

The panel carefully considered the period of the suspension order and determined that a suspension order for a period of 6 months was appropriate in this case, to mark the seriousness of the misconduct and allow Miss Ntsikizana sufficient opportunity to produce evidence of insight and remediation The panel did not accept the submission of Ms Williams that a period of 12 months was required. In the view of the panel 12 months suspension would be disproportionate and would have an unduly punitive effect.

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

Any future panel reviewing this case would be assisted by:

- Attendance at any future hearing
- Reflective account focusing on record keeping, duty of candour and dishonesty
- Reference or testimonials from any work, paid or unpaid
- Evidence of keeping up to date with current nursing practices and maintaining professional development.

This will be confirmed to Miss Ntsikizana in writing.

**Interim order**

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order 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 Ntsikizana's own interest until the suspension 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 Ms Williams. She submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest.

Ms Williams invited the panel to impose an interim suspension order for a period of 18 months.

**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 allow sufficient time for an appeal to be made if Miss Ntsikizana wishes to make one.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Miss Ntsikizana is sent the decision of this hearing in writing.

That concludes this determination.