Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
25 October – 2 November 2021
28 - 30 March 2022

Virtual Hearing

Name of registrant:	Reni Vankova Kirilova
NMC PIN:	15F0229C
Part(s) of the register:	Registered Nurse – Adult Nurse-Sub part 1
Area of registered address:	Bristol
Type of case:	Misconduct
Panel members:	John Vellacott (Chair, lay member) Catherine Askey (Registrant member) Lorna Taylor (Registrant member)
Legal Assessor:	Charles Parsley (25 October – 2 November 2021) Oliver Wise (28 -30 March 2022)
Panel Secretary:	Tyrena Agyemang (25 October – 2 November 2021) Amira Ahmed (28-30 March 2022)
Nursing and Midwifery Council:	Represented by Yvonne Ferns, Case Presenter
Miss Kirilova:	Present and represented by James Doyle (25 October – November 2021), Ramya Nagesh (28-30 March 2022) instructed by the Royal College of Nursing (RCN)
No case to answer	Charge 1e
Facts proved:	Charges 1a, 1c, 1d and 1f
Facts not proved:	Charge 1b

Fitness to practise:	Impaired
Sanction:	Suspension order (3 months)
Interim order:	Interim suspension order (18 months)

Details of charge

That you a registered nurse:

1) On 30 May 2019:

   a) Forced medication into Patient A's mouth with a spoon and/or with your hand; **[PROVED]**

   b) Once the medication referred to in charge 1a was in Patient A's mouth, placed your hand over her mouth; **[NOT PROVED]**

   c) Once the medication referred to in charge 1a was in Patient A's mouth, held her mouth closed; **[PROVED]**

   d) Whilst attempting to administer the medication referred to in charge 1a, shouted 'take your tablets', or words to that effect, at Patient A; **[PROVED]**

   e) Did not escalate Patient A's refusal to take the medication including that referred to in charge 1a to another member of staff; **[NO CASE TO ANSWER]**

   f) Did not attempt an alternative method of administering medication to Patient A following Patient A's refusal. **[PROVED]**

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

Mr Doyle informed the panel that you made no admissions to the charges.

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

At the outset of the hearing, Ms Ferns made a request that this case be held in private as the papers in this case document the patient in this case's name in full. She told the panel that holding the hearing in private would ensure the patient's name remains in private. The application was made pursuant to Rule 19 of 'Nursing and Midwifery Council (NMC) (Fitness to Practise) Rules 2004', as amended (the Rules).

Mr Doyle had no objections to the application.

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. In this case, the legal assessor stated that it was not necessary for the hearing to be held in private and stated that when referring to the patient, participants should use “Patient A” to ensure the anonymity of the patient.

The panel determined that a Rule 19 application in relation to the patient’s name in the papers was not required and ruled that the hearing will remain in public session.

Decision and reasons on application to admit written statement

The panel heard an application made by Ms Ferns under Rule 31 to allow the written statement of Witness 5 into evidence. Witness 5, a registered nurse on the Avon Unit was not present at this hearing. He was unable to attend virtually due to being abroad on holiday in an area of poor connectivity.

Mr Doyle agreed with the application on the basis that redactions were made to Witness 5’s statement.

The panel heard and accepted the legal assessor’s advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is ‘fair and relevant’, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Witness 5, and would give it what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

The charges arose whilst you were employed as a registered staff nurse at The Chocolate Quarter Care Home, Bristol which is a nursing home run by the St Monica Trust**.** You had commenced employment on 23 May 2019, where it is alleged while working on the Avon Unit with up to 30 residents with dementia on 30 May 2019, you forced medication into Patient A's mouth and put your fingers/thumb over the patient's lips.

The alleged incident took place in the unit's open plan kitchen/dining/lounge area where several witnesses were present.

You continued to work after 30 May 2019, but were suspended on 7 June 2019, pending a safeguarding and police investigation. You resigned from your post on the same day, citing incompatible working conditions. The home manager also made a referral to the NMC with concerns regarding your fitness to practice.

You were interviewed by the police whose investigation was finalised with no further action being taken.

Opening Submissions on Facts

Ms Ferns told the panel that you were working on the evening shift and were responsible for patients. She told the panel that your reply to the Case Management Form (CMF) details your response to the charges, of which you deny all the charges and confirm that you are not impaired by your misconduct.

Ms Ferns told the panel that Witness 1 was a Carer working at the home and she described you forcing medication into the patient's mouth and then putting your fingers over the patient's mouth and lips to keep them closed. She told the panel that Witness 1 stated that you said something like, *"Patient A take your meds"* and kept repeating *"she needs to take her meds"*.

Ms Ferns told the panel Witness 2 worked as a Catering Assistant at the home. She told the panel that Witness 2 saw you forcing medication into the patient's mouth and putting your thumb over Patient A's lips to hold her lips shut for just under a minute. She told the panel that Witness 2 stated that you were shouting at the patient *'take your tablets Patient A'* and repeated this about three times.

Ms Ferns told the panel Witness 3 worked as a Catering Assistant and she who witnessed you forcing medication into the patient's mouth by hand using your thumb to push against your mouth to push the medication back in and that it was a lengthy hold trying to keep them there.

Ms Ferns told the panel that Witness 4 was the Registered Home Manager for the Chocolate Quarter at the time of the incident. She told the panel that the witnesses reported that they saw you forcing tablets into a patient's mouth and placing fingers in the patient's mouth. Ms Ferns told the panel Witness 4 stated that she would have expected the nurse to try different approaches to medication administration if not successful and ask for medication trained colleagues to assist to see if Patient A was more receptive to receiving medication from them.

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

- Witness 1: Former Carer now Senior Carer and former colleague
- Witness 2: Catering Assistant and former colleague
- Witness 3: Catering Assistant and former colleague

- Witness 4: Registered Home Manager for the Chocolate Quarter and Registered Nurse

Decision and reasons on application of no case to answer

The panel considered an application from Mr Doyle that there is no case to answer in respect of charges 1e and 1f. This application was made under Rule 24(7).

In relation to charge 1e, Mr Doyle submitted that there is evidence before the panel in the Patient Assessment Form dated 30 May 2019, completed at 21:00 with a brief outline of the circumstances that the patient was: *"attempting to spit her medications, probably we have to speak with GP for covert meds".*

Mr Doyle told the panel that this is evidence you intended to escalate the incident, but he submitted that it is unclear which members of staff were present at the time of the incident in order for you to seek advice from.

In relation to charge 1f, Mr Doyle told the panel that you were unable to seek alternative methods of administering medication. There is limited evidence that you had the opportunity to seek alternative methods. He referred the panel to the case of R v Shippey [1988] Crim LR 767. The comments provided by Turner J explain that *'evidence at its highest'* did not mean *'picking out the plums and leaving the duff behind'*; meaning that just because some parts of the evidence supported the prosecution case did not mean that a case should inevitably go before the jury.

Mr Doyle submitted there is plenty of evidence that details the context to the incident, but he submitted it cannot be said that something has not been done, if there was no opportunity to do it. He therefore submitted that these charges should not be allowed to remain before the panel.

Ms Ferns opposed the application made by Mr Doyle. She submitted that any decision, at this stage, is a matter for the panel's judgment.

In relation to charge 1e), Ms Ferns submitted that you did not escalate Patient A's refusal to take the medication to another member of staff and that there is no evidence that you escalated Patient A's refusal to take the medication to another member of staff. She submitted that the charge is in relation to what actions you took at the time of Patient A's refusal rather than the completion of a form. She told the panel that Witness 4 stated that on an average day there are about 9 staff and a Unit Manager. Ms Ferns further submitted that there is no evidence of you referring to a more experienced member of staff or seeking assistance of any kind. She referred the panel to Witness 4's statement that *"a floor would have the following staff; a Unit Manager, Registered Nurse, 2 or 3 Senior Carers, at least 3 care workers and that the evening would have the same complement and an extra care worker"*.

Ms Ferns told the panel that in Witness 4's statement she said: *'I would ask medication trained colleagues to assist to see if resident was more receptive to receiving medication from them'* and *that 'If the resident still did not want to take medication, she would contact the GP for advice at that time and desist in trying to give that medication as this could give resident emotional distress'*. She submitted that sufficient evidence has been presented for this charge to proceed.

Ms Ferns then addressed charge 1f) and submitted that you did not attempt an alternative method of administering medication to Patient A following the refusal of medication. She submitted that this charge is in relation to what actions in terms of alternative methods you took following Patient A's refusal of the medication at that time. She submitted that there is no evidence of you attempting to try administering the medication in any other way.

Ms Ferns then referred the panel to evidence from Witness 1, who is now a Senior Carer and is trained to administer medication, but at the time was a carer without that training. She stated that *'this would not have been the way I approach residents when giving medication'*. Ms Ferns told the panel that in her live evidence, Witness 1 stated what she learnt in training to give medication and working with Dementia patients, a nurse needs to be '*a bit patient, get them at right moment, more rapport, get them to trust, not trying to do anything hasty'*. Ms Ferns submitted that there is evidence from Witness 4 who said, *'I would expect the nurse to try different*

approaches to medication administration if not successful'. She submitted that sufficient evidence has been presented for this charge to proceed.

Ms Ferns told the panel that the case must be assessed as a whole. She referred to the case of R v Galbraith (1981 73 Cr App R 124). If the evidence is conflicting, then she submitted the case would fall foul of the second limb of Galbraith.

Ms Ferns further submitted that there is strong evidence to support these charges and accordingly she invited the panel to determine there is a case to answer on both sub charges.

The panel took account of the submissions made and heard and accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer.

The panel was of the view that, taking account of all the evidence before it, there was not a realistic prospect that it could find the facts of charge 1e proved. The panel considered that the NMC had not presented any evidence that supported the allegation that you did not escalate the concerns regarding Patient A. In oral evidence, Witness 1 was asked if she knew whether you had escalated the concerns and she replied that she didn't know. In her witness statement she stated: *"Reni then scooped medication and walked away to the clinical room. She did not say anything further to me."* The panel considered that there is no evidence the escalation did not occur. The panel noted that at 21:00 you made an entry in Patient A's continuation assessment form that: "*Patient A attempting to spit her medications. probably we have to speak with GP for covert meds."*

The panel considered this entry in the patient notes to a step to escalate the concerns which was appropriate in the circumstances. The panel further noted that in the oral evidence of Witness 1 she stated that since the incident the method of

administration of medicines to Patient A had been changed which may be consistent with action having been taken in response to your entry in the continuation assessment form.

The panel was not assisted by the medication care plan in the exhibit bundle because of its contradictory content and it was not clear that it reflected the regime that was in place at the time of the incident.

The panel could not be satisfied that the charge could be found proved.

In regards to charge 1f the panel considered all the evidence before it and was of the view that there is a case to answer. The panel considered that evidence of Witness 1 in which she stated she expected her to try get another nurse who was well known to the patient to try and give the patient her medication. The panel also considered that there is no evidence that you tried another technique that would not cause distress to the patient and allow you to safely administer the medication.

The panel therefore find there is a case to answer in respect of this charge.

Your Case

The panel heard evidence from you under affirmation.

You told the panel that started working on the Avon Ward on 23 May 2019, but for this you completed an offsite induction course over four to five days.

In questioning by Mr Doyle you took the panel through your nursing career to date and told the panel that when you started work on the Avon Unit, you were not mentored and did not work directly with Witness 5 as asserted in his statement. You told the panel that you had one day of shadowing another member of staff, who was an agency nurse, but after that you were administering medication to patients on the unit and working alone. You told the panel that there were members of staff around who would answer your questions, but that you did not work on a supernumerary basis at any point.

You were referred to the MAR Charts which displayed your signature. This you said, signified that Patient A had taken her medication, as you would not sign the chart if the patient had refused or the administration was not successful.

When asked if you recalled being in the dining area, you stated that you did not originally remember, but you were reminded by the patient's name. You told the panel that you were trying to convince Patient A to take her medication and you said, "*please take your medication."*

You told the panel that you recall being given a pill by Witness 1 from the floor and that this is common in the home for medication to be found on the floor. You told the panel that there are a number of patients in the home and that pills are sometimes on the floor for two to three days. You told the panel that you do not remember Witness 3 talking to you about covertly administering the medication to Patient A.

When asked if you forced the spoon with the medication into the patient's mouth, you told the panel that the patient opened her mouth and took the pill with water and that you lifted the patient's chin to assist her. If the patient had spat out the tablet, you would not have signed the MAR Chart. You said that the patient always took her medication with water and that the tablets were administered with a spoon. You told the panel that the patient did not like the taste of the tablets and that this is when you asked for some juice for the patient. You stated that you had to shout to other members three times before someone brought you the juice. You stated that while you were waiting for the juice you were holding the patient's chin. You told the panel that the patient could swallow normally, but sometimes there is spillage and that is why you assisted the patient.

Mr Doyle referred you to the continuation sheet and you told the panel that you made this entry because you could not speak to the GP on that day as the surgery was closed.

You told the panel that you did not work the day after the incident, but the completed form would raise the concern at handover and that the next nurse on duty should

have acted upon it. You told the panel that you do not remember the nurses name who you handed over to as you were new.

When asked if you treated Patient A before 30 May 2019, you said yes, and that the patient had been cooperative, when she took her medication.

You took the panel through your shift patterns after 30 May 2019. You stated that on 6 June 2019, you received a call from Ms 1 the Unit Manager, who told you not to come in to work. You explained to the panel that you were upset by the call and on 7 June 2019 you resigned from your post.

You told the panel that the police interview was a very distressing experience but, that you answered the police questions to the best of your ability.

In cross examination you told the panel that you do not remember exactly which shifts you worked with Witness 5 and that, while he was available to answer questions, you did not consider this to be mentorship as he was working on the other half of the unit rather than working along side you. You told the panel that you did not feel completely confident while working as you were new to the unit and the patients had dementia which could make them unpredictable.

You told the panel that you were told during a handover that Patient A had previous safeguarding issues. You explained that the medication Patient A was taking was not time sensitive and the timings recorded on the chart were a close approximation of when they were administered. You also told the panel that you would not have made the entries if the medication had not been administered.

You accepted during questioning that you were following the patient trying to administer the medication. You told the panel that the patient opened her mouth and that is when you gave her the medication and that it was not forced.

You told the panel that you were not aware when Witness 2 arrived as you were focused on the patient. You told the panel that there was one catering assistant

approximately two to three steps away from you in the room and that she would have seen everything.

You stated that you always use *"please"* and *"thank you"* when administering medication to patients and you were clear you said *"please"* repeatedly to Patient A during the incident. You told the panel that you did not hold the patient's lips shut, and that you were only holding her chin to avoid spillage.

You accept the patient was distressed, but stated that it was only for a couple of minutes and that you thought Witness 1 then took the patient away to her room. You told the panel that neither Witness 1 nor any other member of staff informed you that the patient had spat out her medication and so you assumed that the administration was successful.

When asked by Ms Ferns about alternative methods of administering medication you told the panel that it is not an easy process. You stated that the patient's family have to be contacted and then the GP has to be consulted and that you are not able to change the method by yourself.

In questioning by the panel, you stated that it was normal to give patients tablets on a spoon and that the patient did not have any issues with swallowing. You told the panel that you did not see the patient spit out the tablet, but that you cannot remember exactly what happened. You stated that after 30 May, you had no further issues with Patient A refusing or spitting out her medication.

You told the panel that during the incident you were not concentrating on the staff around as your main focus was that patient. You told the panel that you tried to give the patient medication twice and that she could not spit out the tablets as she had water in her mouth.

Closing Submissions

Ms Ferns referred to her written submissions in which she had quoted her own notes of the evidence. She referred to the remaining charges and reminded the panel that

you have made no admissions. She gave the panel her overview of the evidence given by each NMC witnesses and of your evidence.

In relation to Charge 1a, Ms Ferns submitted that when questioned during cross-examination as to whether Patient A was distressed when being administered medication you confirmed that Patient A was a 'bit distressed' but, this was after she had been given the tablet. Ms Ferns told the panel that it was clear from Witness 3's evidence that Patient A was distressed.

In addition, Ms Ferns submitted that there is evidence from Witness 1 who said that the patient was 'distressed' throughout the episode and that she was 'waving her hands everywhere' and was shouting, 'no, no, no'.

Ms Ferns told the panel that Witness 1 confirmed in her evidence that she saw your 'fingers go over the patient's mouth and the patient was *'flapping her hands'* and *'trying to spit them out'*. Ms Ferns submitted that your response in cross-examination was, 'No' and that Patient A was 'always waving her hands'.

Ms Ferns told the panel that the evidence from Witness 2 was that although she had seen Patient A distressed before, she had *'never seen her **that** distressed before'*. Witness 2 described seeing the spoon going in and out of Patient A's mouth. Patient A was saying "no, no, no" and was "quite distressed".

When you were questioned by the panel regarding putting the spoon into Patient A's mouth, you explained that Patient A opened her mouth, but she did not want to drink, because she didn't like the taste. However, your explanation was disputed by Witnesses 1 and 3. Ms Ferns referred the panel to their evidence in which they described you forcibly administering the medication.

Mrs Ferns told the panel that you explained Patient A was sitting on a chair when you administered her medication and that after speaking with her she opened her mouth to receive the medication. You explained there were plenty of people in the vicinity. However, when cross-examined you conceded that Patient A was only sat

on the chair ‘for a moment’ and was ‘standing’ when you administered the medication.

You told the panel that you were not concentrating on who was present as you were concentrating on the patient. However, in cross-examination, you told the panel that Witness 3 was in the kitchen standing ‘one or two steps’ from you and the patient and she saw you administering medication to Patient A.

You stated in your evidence that you shouted for juice but Witness 2 confirmed in cross-examination that she had not heard you ask for a glass of juice. Ms Ferns told the panel that when it was put to Witness 1 that Patient A had a sip of water and you put her hand under Patient A’s chin to stop her from spitting the tablets out, Witness 1 stated, *“No, that didn’t happen.”*.

Ms Ferns told the panel that you were unable to explain why none of the witnesses recall hearing you ask for juice or seeing you give Patient A some juice. You explained that she refused her medication “because of the taste”. Witness 1 stated she did not hear the word “taste”.

Ms Ferns stated in your evidence that you said you always had a *“plastic spoon and glass of water”,* “*yes, all the time”*. However, in live evidence, when Witness 2 was cross-examined as to whether she saw a glass of water she said, ‘No’.

Ms Ferns told the panel that when asked whether you were of the opinion that staff had ‘engineered’ this allegation out of nastiness, you stated that *‘no, they weren’t nasty’*.

In relation to Charge 1b, Ms Ferns submitted that you denied you used your thumb or finger to close Patient A’s mouth. You stated you have *to assist the* patient as they are unable to lift their heads, which would otherwise drop. In your evidence you described the actions you would use to achieve this, holding your hand under the patient’s chin and tilting the head up. This was disputed by Witness 1 who described you putting your fingers over the patient’s mouth to stop her from spitting the tablets out. This was also disputed by Witness 2 who stated that she saw you forcing the

tablets, which were on a spoon, into the patient's mouth and then place your thumb over the patient's lips to hold them shut.

Ms Ferns told the panel that Witness 3 described you taking the medication in your hand and forcing it into the patient's mouth using your thumb to push against the patient's mouth to push the medication back in.

In relation to Charge 1c, Ms Ferns submitted that you denied holding Patient A's mouth closed and demonstrated how you placed your hand to hold up Patient A's chin. She told the panel that the evidence by Witness 1 refutes this, and she said that you had your 'finger and thumb holding mouth shut… 20, 30 seconds'. During cross-examination, Witness 2 also confirmed that you *'had your thumb on Patient A's lips and it didn't come off*'. Ms Ferns told the panel that when it was suggested to her that she didn't see it correctly, Witness 2 replied, 'I did see that correctly'. Ms Ferns stated that when Witness 2 was questioned about how long your thumb remained on Patient A's lips, she said '*about 30 seconds'*, but that Witness 2 stated that, "*the thumb went on quickly and didn't come off".*

Ms Ferns told the panel that while the witnesses assessed the length of the incident differently, they all considered it to be a lengthy hold which could have lasted up to a minute and that whilst this was happening the patient was shaking her head and trying to push you and your hand away.

Ms Ferns submitted in relation to Charge 1d, that you gave evidence and stated that you told Patient A *"take your meds, please"*. Ms Ferns submitted that this is disputed by Witness 2 who stated you said, "*Take your tablets Patient A', three times"* and that "*there was no, please"*. In her statement, Ms Ferns told the panel that Witness 2 was clear in her evidence that you held the patient's lips shut for just under a minute whilst shouting 'take your tablets' about three times.

Ms Ferns moved on to address the final sub charge, Charge 1f. She submitted that when you were asked by the panel, why you used a spoon to administer the medication to Patient A, you explained patients can't always understand how to take their medication from their own hands and put it in their mouth.

Ms Ferns told the panel that having heard the evidence from Witness 4 that Patient A's Medication Care Plan was printed on 5 August 2019 and made reference to Patient A's preference of 'taking one or two tablets at a time, placed in her hand and with a glass of water', the panel may form the view that Patient A did have capacity.

Ms Ferns submitted that as the nurse in charge of Patient A for the shift on 30 May 2019, it was open to you to seek assistance from a GP in relation to alternative methods of administering medication, if a patient was refusing to take their medication. Ms Ferns submitted that when you were asked whether you had the option to call a GP you confirmed that you did have that option, but you stated it was too late in the evening to contact the out of hours GP Surgery, it would be the Doctor on-call, and that you were *"not going to call for one tablet"*.

Ms Ferns submitted that Witness 4 in her evidence stated that, *"If the resident still did not want to take medication, she would contact GP for advice at that time and desist in trying to give that medication as this could give resident emotional distress*". When cross-examined as to whether she would tip the chin up of a Patient when taking meds and she replied, "*No, because that would be abuse"*.

Ms Ferns submitted that having heard the evidence provided by you, the panel may form the view that there are many inconsistencies in your evidence. She stated that when you were asked questions by the panel you would often reply, *"I can't remember"* which is understandable considering that this incident occurred nearly two and a half years ago. However, moments, later after saying that you could not remember, you would come back with an answer to the question. She submitted that it therefore felt at times that you were providing answers to questions asked of you as to what you thought might have happened, rather than asserting in your evidence, what you were actually sure happened. Ms Ferns gave an example, of when you were asked by the panel whether you recalled if Patient A spat out the tablet, you asserted that if the patient spat out the medication, you would give it again. You explained you did not remember exactly what happened, as it was 5 minutes, in one day and you were new.

Another example, Ms Ferns submitted was when you were asked by the panel whether Witness 1 said, there were "*better ways of doing this*", you said, "*No, she didn't say anything about better ways", "at this moment no"* but then you said, you couldn't remember, that she probably said something.

Ms Ferns then gave another example, when you were asked by the panel who was there when you were administering medication. You replied that you were not paying attention to who was around you as you were focusing on Patient A. Yet, when it was put to you in cross-examination, you stated that Witness 3 was not there.

Ms Ferns submitted that in stark contrast to this, Witness 1, 2, 3 and 4, could remember the incident quite well and provided clear, consistent evidence. She stated that they were credible witnesses who were emphatic in their evidence of what they recalled and importantly, what they could not recall. She submitted that their live evidence was consistent and supported the charges which are before the panel.

Ms Ferns submitted that the NMC's witnesses had a better recollection of events on the 30 May 2019 which was aided by their written statements.

Ms Ferns told the panel that you were interviewed by police after the incident on 30 May 2019 and the police made the decision not to prosecute. However, she submitted that the standard of proof for criminal prosecutions is different from the civil standard of proof. She therefore submitted that the police's decision not to proceed with their case should not impact on any decision the panel make.

In the circumstances and based on the evidence, on the balance of probabilities, she invited the panel to find the remaining charges proved.

In his submissions, Mr Doyle acknowledged that the panel might have a sense of unease about your evidence as you have not been able to provide a detailed description of the Avon Unit and its working practices. He invited the panel to look at

the context surrounding the incident and he submitted that the events have not been reported accurately by the witnesses in this case.

He stated that your “induction” at the home took place off site and that it involved listening to a series of lectures rather than being hands on.

Mr Doyle highlighted the discrepancies about the staffing levels and the challenges the home faced. He submitted that there was an enormous burden on a new starter and very little support. He submitted that the evidence from Witness 5 is not accepted, and he invited the panel to accept you had not been mentored and that you had to seek advice from those around you.

Mr Doyle told the panel that there was a lack of process in the evidence of Witness 4. He referred to the deficiencies in the documentary evidence and he told the panel that there was no evidence provided regarding possible entries or absence thereof in the Health and Safety Log and there was no information documented on a continuation sheet. He told the panel that concerns were raised, and statements were taken, but no effort was made to speak to you to obtain your response. You were suspended and told not to come to work.

Mr Doyle also highlighted a failure in obtaining a copy of the police interview. He stated that the burden of proof is different in criminal proceedings and the factors involved in the decision to charge someone is made by the Crown Prosecution Service (CPS). He told the panel that the CPS made the decision not to charge you as there was insufficient evidence. He told the panel that there is no evidence of what was said during the police interview, but the response from the police was that you gave a plausible account. He told the panel that there was no attempt from the NMC to obtain a copy of the interview. Mr Doyle raised a general concern in relation to this, to the evidence heard by the panel and the process of investigation by the NMC.

Mr Doyle submitted that you were working two days later and there were no issues raised. He reminded the panel that you said the allegations made you feel like a nasty person as in your opinion, only a nasty person could do something of this

nature to a vulnerable patient. He also reminded the panel that you found the police interview traumatic, he submitted that the panel is not dealing with a cold-hearted individual, but a nurse who can relate to patients with dementia.

Mr Doyle submitted that although the events at 17:00, do not appear to be the subject of the allegations, he stated that it does assist in the way to approach the evidence of Witness 1. He told the panel that a broad brush effect of your evidence is that having arrived in the dining room at 17:00, she was given a pill by Witness 3 and then she witnessed the incident in question. Mr Doyle submitted that there are issues with the sequence of events and reliability of Witness 1. He submitted that her evidence is potentially unreliable as she doesn't seem to have a clear recollection of the incident. He stated that both Witnesses 2 and 3 state in their statement that Witness 1 arrived on the scene at the end of the incident and so he questioned what reliable evidence she would be able to provide in light of this.

Mr Doyle told the panel that in questions to Witness 1 he asked her what she actually saw, and she said it felt "forced" and that it was too quick. Mr Doyle questioned whether the essential complaint from what the witnesses saw, was that the patient was not enjoying the process. He told the panel that there is evidence that they had seen patient A become distressed when taking her medication, but their general feeling was that in terms of the process of administering medication to the patient that it was done too quickly.

Mr Doyle submitted that there is inconsistency between witnesses. Witness 3 clearly remembers the patient talking about taste, but this is denied by Witnesses 1 and 2. He told the panel that Witness 3 stated that there was water provided for the patient, but this is disputed by Witness 2. He also stated that shouting is mentioned in the statement of Witness 2 but is not supported by Witness 3.

Mr Doyle addressed the aspect of Patient A allegedly spitting out the tablet. He submitted that this is mistaken evidence as there is no mention of spitting or hands in the mouth but Witness 2 again talks about the swiftness of your actions.

In summary, Mr Doyle invited the panel to consider the reliability of the witnesses and the evidence before the panel. He asked the panel to consider to what degree is the evidence reliable. He submitted that looking carefully at the events, in conjunction with your evidence, the burden of proof is not discharged.

Decision and Reasons on Facts

In reaching its decisions on the remaining charges, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Ferns on behalf of the NMC and by Mr Doyle on your behalf.

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 accepted the advice of the legal assessor

Charge 1a

That you a registered nurse on 30 May 2019:

a) Forced medication into Patient A's mouth with a spoon and/or with your hand;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1, 2, 3 and your evidence.

The panel considered that the use of the term "force" implies a degree of coercion, (although not necessarily implying physical force) which overrides the will or lack of consent of the patient. The panel noted that Witness 1, 2 and 3 all used the word "force" in their NMC witness statements and in their oral evidence.

The panel also noted that there is cogent and consistent evidence from Witnesses 1, 2 and 3 that the patient was shouting “no, no, no” and refusing to accept her medication from you. Both Witness 1 and 2 asserted it was not unusual for Patient A to refuse her medication.

Witness 2 said she had seen Patient A upset before, “but not **that** upset”. Witness 2 and 3 used the word “shock” when describing their feelings about the incident and stated they would not like a member of their own families to be treated in such a manner. Both witnesses cited that this was one of the reasons they reported this incident to the manager.

The panel considered your acknowledgement that the patient was saying *“no no no”* and that she has a right to refuse medication. The panel also noted that Witness 1 reported that in her experience, the method of dispensing medication that you employed was not normal procedure.

Witnesses 1, 2, and 3 describe seeing you use a spoon. Although Witness 3 also recalls seeing you pushing the medication back into the patient’s mouth with your thumb. Your evidence was that, at least initially you were using a spoon in your attempt to administer medication.

The panel preferred the evidence of the NMC witnesses with regards to this charge to your version of the circumstances and therefore concluded on the balance of probabilities, that your administration of medication with a spoon and/or your hand was indeed forced and found this charge proved.

Charge 1b)

That you a registered nurse on 30 May 2019:

b) Once the medication referred to in charge 1a was in Patient A’s mouth, placed your hand over her mouth;

This charge is found not proved.

In reaching this decision, the panel took into account the evidence of Witness 1, 2, 3 and your evidence.

The panel took account of the wording of the charge and considered that this charge implies you placing your whole hand over the patient's mouth. The panel noted that none of the NMC witnesses stated seeing you place your whole hand over the patient's mouth.

At most the NMC witnesses describe your placing a finger and/or thumb to the patient's mouth. You stated you were attempting to assist the patient to swallow her medication with water. You said that except perhaps for your thumb, being in close proximity to the patient's mouth, your hand was not covering it.

The panel was not persuaded that there was evidence that your hand was placed over the patient's mouth. The panel therefore find this charge not proved.

Charge 1c)

That you a registered nurse:

1) On 30 May 2019:

c) Once the medication referred to in charge 1a was in Patient A's mouth, held her mouth closed;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witnesses 1, 2, 3, 4 and your evidence.

The panel acknowledged Witness 1, 2, and 3 all describing a protracted manoeuvre in which you held the medication in the patient's mouth.

Witness 1 recalled seeing you force the medication into Patient A's mouth with a spoon, then saw your fingers go over her mouth and see you hold them there for 30 seconds. Witness 2 stated she observed you force the tablets into Patient A's mouth with a spoon she then recalls you place your thumb over Patient A's lips and hold it there for just under a minute. Witness 3 states she saw you put the medication in Patient A's mouth with your hand and when Patient A spat out the tablets, and you pushed them back in with your thumb. She then saw you hold your thumb on the patient's mouth in a "lengthy hold". Witness 4 asserted that holding the patient's mouth closed by any means would be inappropriate.

The panel preferred the evidence of the NMC witnesses with regard to you using your thumb and/or fingers to keep the patient's mouth closed.

The panel has noted your evidence that you had given the patient water to aid with the swallowing of the medication and that you were trying to facilitate the patient's swallowing reflex by tilting the patient's chin upward.

The panel is nevertheless satisfied that even on your account, you were holding the patient's mouth closed in order to achieve the objective of getting the patient to swallow the medication. Consequently, on the balance of probabilities the panel find this charge proved.

Charge 1d)

That you a registered nurse:

1) On 30 May 2019:

d) Whilst attempting to administer the medication referred to in charge 1a, shouted 'take your tablets', or words to that effect, at Patient A;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 1, 2, 3 and your evidence.

Witness 1 described you “actually insisting that Patient A should take her tablets she” (you) “kept repeating “she needs to take her meds””. Then Witness 2 said in her statement you were shouting “take your tablets Patient A”, and kept repeating this. Witness 3 described Patient A becoming angry and hearing raised voices, “both… seemed to be getting frustrated”.

The panel also noted that Witness 3 spoke of hearing raised voices, mostly from Patient A. The panel inferred from this that you did raise your voice drawing at least one witness’ (Witness 1) attention to the situation. The panel therefore find this charge proved.

Charge 1f)

That you a registered nurse:

1) On 30 May 2019:

f) Did not attempt an alternative method of administering medication to Patient A following Patient A’s refusal.

This charge is found proved

In reaching this decision, the panel took into account the evidence of Witnesses 1 and 4 and your evidence.

The panel noted your admission that you had not attempted any alternative methods of administering medication to the patient.

The panel was told by Witness 1, who was not a senior carer at the time but had been working with the patient as a carer:

> *"She wasn't even asking her whether she wanted to take her medication or speaking to her about it as I would expect her to do. I would definitely say that when you need to give medication you should have a chat with the resident and ask them how they are, make them a cup of tea if you can, but above all get them to trust you."*

In her witness statement, Witness 4 said that "*Patient A was living with dementia, she had no capacity and received full assistance with medication."* In her oral evidence Witness 4 stated that you should not have persisted while the patient was so distressed. You could have approached the unwillingness of Patient A to accept her medication in a number of ways. You should have been aware that you could have asked another member of staff who was more familiar with the patient to assist you; you could pause and attempt to build trust to administer the medication. If these methods failed, you could have contacted an on-call manager for advice or telephoned the out of hours GP.

The panel considered that at the very least you could have engaged the support of experienced carers to calm the patient and offer biscuits and a drink before further encouragement to take the medication.

The panel considered the alternative actions suggested by Witnesses 1 and 4 to be reasonable alternative approaches when dealing with a patient lacking capacity who was reluctant to accept medication. The panel was satisfied that you do not appear to have considered any alternative methods but persisted in your attempts to force the medication into the mouth of the patient who was clearly distressed.

Fitness to practise

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

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

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

Submissions on misconduct

Ms Ferns invited the panel to take the view that the facts found proved amount to misconduct. 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.

Ms Ferns identified the specific, relevant standards where your actions amounted to misconduct. She submitted that your use of inappropriate force including forcing medication into a patient's mouth and holding it closed, amount to misconduct. She submitted that your failings are serious and fall short of what would be expected of a registered nurse in the circumstances. She explained that the areas of concern identified relate to basic nursing skill requirements.

Ms Ferns submitted the failings involve a serious departure from expected standards and put patients at risk of harm. She submitted that these failings are likely to cause risk to patients in the future if they are not addressed. Ms Ferns submitted that your actions were inappropriate towards Patient A, who was a patient suffering from dementia and would be regarded as deplorable by other nurses and the general public.

Ms Nagesh did not argue against a finding of misconduct.

Submissions on impairment

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

Ms Ferns submitted that your actions placed Patient A at unwarranted risk of harm. She explained that Patient A was a very vulnerable patient who was suffering from dementia and whose emotional welfare was impacted as your actions caused her immense distress throughout the incident. She submitted that you have made no admissions to the charges and therefore do not admit that your actions were wrong.

Ms Ferns submitted that given the seriousness of this case and the failings identified, the panel may conclude that a finding of impairment on both public protection and public interest grounds is required and that your fitness to practice is currently impaired.

You gave evidence under affirmation. You submitted that you are currently working as a senior care assistant in a residential Home in which many of the residents have dementia. You stated that you are liked and trusted by the residents including those with dementia.

You submitted that if you were in a similar situation again and felt unsupported at work you would speak to management and ask for support. You also apologised for your actions for the distress you caused to patient A and to the staff that were present at the incident but you indicated that the staff should have helped you. You submitted that in the future you will be very careful when you are administering medicine. You explained when you do not know a resident you will take a colleague who knows them better to support you in administering any medication.

Ms Nagesh referred to *'The NMC guidance on Insight and Strengthened Practice'* which states that evidence of your insight and any steps you have taken to strengthen your practice will be central to deciding whether you are currently impaired. She submitted that you have undertaken a number of training courses that are targeted to the particular areas of concern. She submitted that these are courses that you took voluntarily and on your own initiative and they cover safely providing medicines to those suffering from dementia.

Ms Nagesh submitted that you have also demonstrated insight into your previous conduct in your evidence to the panel, both in writing and orally today. She submitted seeing all that you have done and seeing the high regard in which you are held by your residents and colleagues the panel can consider that your fitness to practice is not currently impaired.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

The panel was of the view that your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to.

1 Treat people as individuals and uphold their dignity

1.1 treat people with kindness, respect, and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

2.4 respect the level to which people receive care want to be involved in decisions about their own health, wellbeing and care,

2.5 respect, support and document a person's right to accept or refuse care and treatment,

2.6 recognise when people are anxious or in distress and respond compassionately and politely,

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

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your failings involve serious departures from the expected standards of a registered nurse in the profession of fundamental care and in treating patients with respect and compassion. Your conduct caused patient A emotional distress and could have damaged the reputation of the profession with those who witnessed your actions. The panel determined that such conduct could put patients at risk of harm and therefore amounted to misconduct.

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 that patient A was put at risk of harm and was caused emotional harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that you had made significant progress and have reflected on what you have done wrong. However the panel was not satisfied that your insight has developed so far to allow it conclude that your fitness to practise is not currently impaired.

The panel was satisfied that the misconduct in this case is capable of remediation. Therefore, the panel carefully considered the evidence before it in determining whether or not you have strengthened your practice. The panel took into account your relevant training courses, the four testimonials you provided, two of which were from carers, one from a registered nurse and one from your regional manager, and your reflective piece. In this reflection you explained that you probably forgot to be courteous with 'please' and 'thank you' when speaking to patient A as you were in a stressful situation, being unfamiliar with the Home and residents. You told the panel you would try to be more professional and keep your voice down in similar situations now. Despite probing questioning from the panel you did not appear to have considered how you would cope with similar stressors in the future in any great detail. You did not appear to acknowledge your role to take the lead in similar situations as the registered and accountable practitioner and as a role model to junior staff.

The panel noted that you have been working in a care setting as a senior care assistant but have not been working as a nurse and therefore have not been administering medication and have not yet had the opportunity to demonstrate you have strengthened your practice in this area. The panel was not convinced that you understand and accept the seriousness of any nurse inappropriately and forcefully treating and handling a patient. The panel was therefore of the view that there is a risk of repetition and decided that a finding of impairment is necessary on the grounds of public protection.

The panel was concerned that your reflection on this incident appeared to be focused on the impact it had on you rather than looking at the wider impact on the patient and the profession.

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

registered nurse and could adversely affect public confidence in the profession. Therefore, a finding of impairment on public interest grounds is also required.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of three months. The effect of this order is that the NMC register will show that your 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 Ferns submitted that a six to nine months suspension order with a review should be imposed in this case. She submitted the sanction bid has been considered by the NMC and a suspension order is the most suitable sanction to address the regulatory concerns.

Ms Ferns submitted that the public protection and public confidence in the profession and the NMC's roles as an effective regulator would not be maintained if a suspension order was not made here today.

Ms Nagesh submitted that you have shown remorse, insight and initiative in improving your practice. She submitted that in order to allow you to strengthen your practice a conditions of practice order should be imposed.

Ms Nagesh submitted that examples of conditions in this case might be supervision from a more senior colleague when you are giving medication to those suffering from dementia or indeed to any patient, the requirement to keep a reflection log that can be provided to the NMC at regular intervals, the requirement to create a personal development plan, or to obtain a report from a superior at regular intervals.

Ms Nagesh submitted that a suspension order would be disproportionate and would not achieve any objectives in terms of getting you back into working as a nurse in a way that your actions and risk to patients can be monitored.

Decision and reasons on sanction

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

- Your behaviour towards patient A, a very vulnerable individual, demonstrated an abuse of your trust. Your actions caused the patient to suffer emotional distress and in addition you put them at risk of suffering actual harm.

- You have been unable to fully explain the thinking behind your insistence that patient A take their medication at that point, or why you didn’t consider calling a halt to the task to allow tensions to settle.

- You have shown limited insight into your failings as in your evidence you have not explored in full how your behaviour may be viewed by the public and how it reflects negatively on the profession in undermining a position of trust.

- You have not demonstrated to the panel that you fully understand that the levels of accountability and responsibility accorded to a nurse are different to those of other staff, and that you alone are accountable for the professional judgements you make.

The panel also took into account the following mitigating features:

- This was a single isolated incident working with a client group that was unfamiliar to you.

- You have voluntarily undertaken training specifically relating to patients with dementia and you are now classed as being a ‘dementia friend’.

- You have shown genuine remorse for your behaviour during this hearing and you have apologised to the staff and patient involved in this case.

- You have already developed some insight into the impact that your actions have had on the patient and colleagues alike.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action, nor would it provide any public protection.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances.

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

The panel was mindful that no lack of competence had been identified within your clinical practice and because the issues of this case related to your behaviour it wouldn't be possible to formulate conditions of practice that were measurable or workable. The panel determined that your lack of sufficiently developed insight into your actions could not have been addressed through retraining alone. Furthermore, a conditions of practice order would not address the seriousness of this case to satisfy the 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 noted that you have shown some insight and have engaged with the NMC process fully.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate at this stage.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel considered that although a suspension order may have a punitive effect it is necessary in this case 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 noted the SG and in particular the section on factors to consider before deciding on sanctions which stated:

> *"The fact that a nurse, midwife or nursing associate was previously under an interim order, and for how long, are relevant background factors in deciding on what a proportionate length of sanction might be."*

When considering the length of this suspension order the panel took into account your efforts to maintain and improve your clinical skills with appropriate training in both medicines and dementia care. You have demonstrated a sincere wish to return to clinical practice despite having been subject to an interim suspension order since June 2019. The panel determined that three months was sufficient to mark the seriousness of this isolated incident. Furthermore, this will give you an opportunity to reflect upon your behaviour and time to take appropriate steps to adequately develop your insight.

The panel took into account the hardship such an order will inevitably cause you. However this is outweighed by the public interest in this case.

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:

- Your attendance at any review hearing;
- A detailed reflective piece, addressing the aggravating factors identified, demonstrating your understanding of the gravity of your actions and the impact on patients, staff, colleagues and the nursing profession, and how you will manage stress in the future;
- Evidence of testimonials from a line manager or supervisor that detail your interactions with patients.

This will be confirmed to you in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Ms Ferns. She submitted that an interim suspension order is appropriate for a period of 18 months to cover the 28 day appeal period.

Ms Nagesh did not oppose the application for an interim order.

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.

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

That concludes this determination.