Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 20 September 2021 – Friday, 1 October 2021
14 – 18 March 2022

Virtual Hearing

Name of registrant:	Huifang Li
NMC PIN:	16F0093E
Part(s) of the register:	Registered Nurse – Sub Part 1 RNA: Adult Nursing – Level 1 (July 2016)
Area of registered address:	Cheshire
Type of case:	Lack of competence/ Lack of knowledge of English
Panel members:	Avril O'Meara (Chair, Lay member) Melanie Lumbers (Registrant member) Robert Cawley (Lay member)
Legal Assessor:	Attracta Wilson
Panel Secretary:	Safa Musad
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Mrs Li:	Present and represented by Wafa Shah, Counsel instructed by the Royal College of Nursing (RCN)
No case to answer:	Charges 2 and 7
Facts proved by admissions:	Charges 1 (partial), 3a (partial), 4a, 6, 8, 9, 12b (partial) and 12d
Facts proved:	1, 3a, 3b, 3c, 3d, 4b, 5c, 5e, 12a, 12b and 13
Facts not proved:	5a, 5b, 5d, 10a, 10b, 11 and 12c
Fitness to practise:	Stage not reached

Sanction:	Stage not reached
Interim order:	Interim conditions of practice order (12 months)

Interim order

Notwithstanding the fact that the panel had made a decision orally on no case to answer and had announced this to the parties, it was not possible to finalise the written determination for this, nor the factual determination, prior to going part-heard during this current listing.

Therefore, the panel invited submissions from the parties as to whether an interim order was necessary in the circumstances of this case, as it had now received all of the evidence on facts, including some admissions from you.

Mr Edwards, on behalf of the NMC, informed the panel that it would need to consider the necessity for imposing an interim order prior to going part-heard. However, he submitted that the NMC remained neutral as to the need of an interim order in the particular circumstances of this case.

Mr Edwards reminded the panel that you had made a number of admissions at the outset of this hearing. He informed the panel that you had previously been made subject to an interim suspension order between August 2018 and February 2019. Subsequently, this interim order was replaced with an interim condition of practice order which was revoked in July 2019. You have been permitted to work as a registered nurse without restriction since then.

Ms Shah, instructed by the Royal College of Nursing (“RCN”), on your behalf, opposed the imposition of any interim order. She informed the panel that you have been practising as a

registered nurse for a significant period of time without any restrictions, you are engaging fully with the NMC, and you can be relied upon to continue to do so.

Ms Shah submitted that you had previously been made subject to an interim conditions of practice order and the panel was satisfied enough to lift them in July 2019.

Ms Shah submitted that if the panel are not minded to agree with her primary submission that no interim order should be imposed, nothing further than an interim conditions of practice order is appropriate in the particular circumstances of this case. Ms Shah submitted that the panel may consider it appropriate to restrict you to your current employer who are aware of the regulatory proceedings and are supportive of you. However, as there has been no findings on facts aside from your admissions, and no material change of circumstances, an interim order is not necessary in the particular circumstances of this case.

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

The panel considered the allegations to be serious, multiple and wide-ranging. It noted that they relate directly to your clinical nursing practice, specifically concerning a number of competency related issues.

As the panel had not finalised its decision on facts, the panel considered whether an interim order is necessary, having regard to the allegations in full, alongside the charges you have admitted.

The panel noted that whilst you have been working as a registered nurse without incident since July 2019, there were some outstanding concerns which you have not yet been able to resolve. The panel did consider there to be a material change in the circumstances of this case, as you have now provided admissions to some of the charges, and have not yet been able to demonstrate that you have addressed any residual concerns relating to them.

In having regard to the above, the panel considered there to be a real risk of repetition and a risk of unwarranted harm to patients in your care, should you be permitted to practise as a registered nurse without some form of restriction.

The panel decided that it would be necessary to restrict your nursing practice on the grounds of public protection, and determined that it was also in the public interest to do so, in order to uphold and maintain proper professional standards.

The panel agreed with the submissions of Ms Shah that an interim suspension order would be disproportionate in the circumstances of this case. The panel was satisfied that the outstanding concerns could be addressed by the imposition of an interim conditions of practice order, as workable conditions could be formulated to protect the public for the period of time it is in force.

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

1. You must confine your nursing practice to your current role as a band 5 registered nurse at Stepping Hill Hospital.

2. You must ensure that you are supervised by another registered nurse or nursing associate when carrying out Hi Flow oxygen therapy and chest drain procedures and management.

3. You must keep us informed about anywhere you are working by telling your case officer within seven days of leaving any employment.

4. You must keep us informed about anywhere you are studying by:
   a. Telling your case officer within seven days of accepting any course of study.

b. Giving your case officer the name and contact details of the organisation offering that course of study.

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

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

7. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   • Any current employer.
   • Any educational establishment.
   • Any other person(s) involved in your retraining and/or supervision required by these conditions.

The panel decided to impose this interim order for a period of 12 months, notwithstanding that the panel were hopeful of concluding this matter at the next listing of this hearing between 14-18 March 2022. It decided that on the abundance of caution, in case there was an issue with any party reconvening on those dates, this would then allow sufficient time for this matter to be relisted. The panel was of the view that a 12 month interim conditions of practice order would allow sufficient time for this matter to be concluded.

Details of charge

'That you, a registered nurse, between 20 November 2017 and 17 July 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 staff nurse in that you;

1) On one or more occasions in December 2017 and/or January 2018 incorrectly increased a patient's nasal cannula oxygen level to above 5 litres. ***[proved by admission]***

2) In January 2018 did not commence a patient's naso-gastric feed at the correct time.

3) On 19 January 2018;

    a) Did not feel for a manual pulse with patients. ***[proved by admission]***
    b) Took an inaccurate oxygen saturation reading for a patient.
    c) Were unable to explain how you could increase a patient's urine output or blood pressure through fluid input.
    d) Were unable to critically analyse patient observations.

4) On 1 February 2018;

    a) Did not check a patient's blood glucose before dispensing gliclazide medication. ***[proved by admission]***
    b) Before putting a nasal cannula on a patient;
        i. Did not check the patient's oxygen saturations
        ii. Did not check the patient's oxygen prescription against the flow meter.
        iii. Did not ensure the oxygen was connected.

5) On 7 February 2018 when completing a quiz on common drugs;

    a) Struggled to identify common drugs.
    b) In relation to amlodipine;
        i. Could not state when it would be omitted.
        ii. Could not state the safe threshold of administration based on a patient's blood pressure.
    c) Did not know what the term "systolic" meant.
    d) In relation to warfarin;
        i. Incorrectly stated that it was used for high cholesterol.
        ii. Did not know what "international normalised ratio/INR" is.
    e) Stated that you would administer cyclizine prescribed to be taken every 8 hours to a patient 6 hours after the last administration.

6) On 30 May 2018 told Colleague 1 that Patient F was ready to be discharged when the medications were not ready and/or the EDNF ('Electronic discharge notification') had not turned green. ***[proved by admission]***

7) On 31 May 2018 breached patient confidentiality by leaving Patient F's EDNF ('Electronic discharge notification') in an out tray without it being concealed inside an envelope.

8) On 16 June 2018, in relation to Patient C;

    a) Did not put water in the bottle when changing the chest drain bottle. ***[proved by admission]***
    b) Did not check or record on the chest drain chart how much fluid had drained. ***[proved by admission]***
    c) Did not record that you had changed the chest drain bottle. ***[proved by admission]***

9) On 18 June 2018, in relation to Patient D, did not follow prompts on Vital PAC to increase the frequency of vital sign recording and/or escalate the patient to a senior nurse or Critical Care Outreach. ***[proved by admission]***

10) On 20 June 2018;

    a) Allowed Patient D to be discharged with a cannula still in place.
    b) Did not make adequate records in relation to Patient D's discharge.

11) In or around July 2018 incorrectly removed a patient's Hi Flow oxygen nasal cannula to administer a nebuliser.

12) On 17 July 2018, in relation to Patient E;

    a) Changed the oxygen level when Colleague 2 had told you not to do so.
    b) Did not wean Patient E's oxygen adequately or at all before converting from Hi Flow to nasal cannula.
    c) Did not connect the nasal cannula to the low flow oxygen meter.
    d) Left Patient E to ask for help rather than use the call bell or shout for help. ***[proved by admission]***

13) Do not have the necessary knowledge of English to practise safely and effectively.

AND in light of the above, your fitness to practise is impaired by reason of your lack of competence and/or lack of knowledge of English.'

Application to amend charges

The panel heard from Mr Edwards, on behalf of the NMC, who requested that a minor amendment be made to the charges in order to clarify the acronyms used in the wording of charges 6 and 7.

The proposed amendment was to outline the meaning of the acronyms used in the charges to read as EDNF (‘Electronic discharge notification’). It was submitted by Mr Edwards that the proposed amendment would provide clarity.

Ms Shah, on your behalf submitted that she had no objections and submitted that by outlining the acronym would provide clarity.

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

The panel determined that no injustice would be caused to either party by such an amendment and that it was appropriate to allow the amendments to ensure clarity.

Decision and reasons on application of no case to answer

Following the conclusion of the NMC case on facts, the panel considered a no case to answer application from Ms Shah in respect of charges 2, 3b, 3d and 7. This application was made under Rule 24(7).

Ms Shah drew the panel's attention to the test set out in the case of R v Galbraith (1981) 73 Cr App R 124 which states that:

> *'If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*
>
> *[Limb 1]*
>
> *The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> *[Limb 2]*
>
> *Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.'*

Charge 2:

> 2) In January 2018 did not commence a patient's naso-gastric feed at the correct time.

Ms Shah submitted that charge 2 falls under limb 2 of Galbraith, in that the evidence presented by the NMC is tenuous in character, weak and vague. She referred the panel to the written and oral evidence of Colleague 3 which goes to this charge. Ms Shah noted that Colleague 3's evidence did not provide any details in relation to this charge and that there is no contemporaneous documentation to support it. Ms Shah submitted that the

evidence presented is vague and inherently weak. Ms Shah submitted that for these reasons the panel cannot properly assess this charge. She therefore invited the panel to find no case to answer under limb 2 of Galbraith in respect of charge 2.

Mr Edwards opposed the application. He submitted that in respect of charge 2, there is a case to answer. Mr Edwards submitted that the panel have yet to hear from you. In respect of the evidence provided by Colleague 3, it was his submission that although the panel do not need to consider witness credibility at this stage, Colleague 3 was a credible, honest and open witness and that there was supporting evidence in respect of this charge.

The panel found no case to answer in respect of charge 2. The panel determined that the evidence relied upon by the NMC is weak and tenuous and does not support the charge. The panel noted that no patient notes or evidence had been provided to show the time of the feed or any delay in administering the feed. The panel noted that Colleague 3, the main witness in relation to this charge, was not the person who had given instructions to you in relation to the feed. The panel was satisfied that a dietitian had given you instructions and the panel had not seen any evidence from the dietitian. Therefore the panel found no case to answer in respect of charge 2.

Charge 3b:

3) On 19 January 2018;

b) Took an inaccurate oxygen saturation reading for a patient.

Ms Shah submitted that charge 3b falls under limb 1 of Galbraith. She referred the panel to the evidence of Colleague 4 which goes to this charge. Ms Shah submitted that Colleague 4 confirmed that she had not checked the saturation reading and confirmed that it could have potentially been an accurate reading. Ms Shah therefore submitted that there is no evidence that you took an inaccurate reading.

In opposing the application, Mr Edwards submitted that the evidence of Colleague 4 was sufficient to support the charge.

Having considered all the evidence, the panel decided there is a case to answer in relation to charge 3b. In particular, the panel took into account the written and oral evidence of Colleague 4 and determined that there was sufficient evidence to support a case to answer.

Charge 3d:

3) On 19 January 2018;

d) Were unable to critically analyse patient observations.

Ms Shah submitted that charge 3d falls under limb 2 of Galbraith. She submitted that the evidence available in relation to this charge is inherently weak or vague and is so tenuous there is no case to answer on this charge. She referred the panel to Colleague 4's evidence and submitted that it lacked specificity and was inherently weak in accordance with the test in Galbraith.

In opposing the application, Mr Edwards submitted that the evidence of Colleague 4 was sufficient to support the charge.

Having considered all the evidence, the panel decided there is a case to answer in relation to charge 3d. In particular, the panel took into account the written and oral evidence of Colleague 4 and determined that there was sufficient evidence to support a case to answer.

Charge 7:

7) On 31 May 2018 breached patient confidentiality by leaving Patient F's EDNF ('Electronic discharge notification') in an out tray without it being concealed inside an envelope.

Ms Shah submitted that charge 7 falls under limb 1 of Galbraith. Ms Shah submitted that Colleague 1 acknowledged she was unable to confirm if you had printed the form or in fact if you put it in the out tray.

In opposing the application, Mr Edwards submitted that you had admitted charge 6 which also related to Patient F's discharge. Although Colleague 1 may well have been unable to confirm that you had printed the form, in light of your admissions to charge 6 and given that you were in charge of Patient F that day, the panel can draw an inference that you put Patient F's EDNF in an out tray.

The panel found no case to answer in respect of charge 7. The panel determined that the evidence relied upon by the NMC is so inherently weak and tenuous. The panel noted that Colleague 1's evidence was that she did not see you put the EDNF form in the out tray. The panel did not accept that your admission to charge 6 was relevant here. The panel therefore found no case to answer in respect of charge 7.

Background

The charges arose whilst you were employed as a Band 5 registered nurse by East Cheshire NHS Trust ("the Trust"). You were employed from 20 November 2017 at Macclesfield Hospital ("the Hospital") on Ward 4 (Respiratory Medicine).

The charges relate to concerns regarding your capability and competency to undertake patient/clinical care to acceptable professional standards and not having the necessary knowledge of English to practice safely. It is alleged that you had an initial two week period of supernumerary status which was standard for all new starters at the Trust. Following concerns during this period, your supernumerary status was extended. It is alleged that between January and March 2018 further concerns were raised regarding your competency, capability and ongoing communication difficulties.

An action plan was formulated focusing on your communication, clinical skills, and medical devices, working within safe parameters and IT skills.

From 26 March 2018, your period of supernumerary practice ended and you were initially performing well as a Band 5 staff nurse. However, between May and July 2018, further concerns were raised in relation to your communication, knowledge, understanding and competencies. At this stage, you were given further support to gain your competencies and you also commenced English lessons. However, further alleged errors took place including a failure involving a patient's chest drain bottle and the incorrect removal of a patient's Hi Flow oxygen nasal cannula to administer a nebuliser.

The concerns raised were wide-ranging and related to both your knowledge of the English language and fundamental aspects of your nursing practice, in respect of your clinical competency.

You subsequently resigned from your post at the Hospital on 17 July 2018. You are now employed as a staff nurse at Stepping Hill Hospital.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Shah, who informed the panel that you made a partial admission to charges 1, 3a and 12b and full admissions to charges 4a, 6, 8, 9 and 12d.

The panel therefore finds charges 4a, 6, 8, 9 and 12d proved in their entirety, by way of your admissions.

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Edwards on behalf of the NMC and by Ms Shah 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 heard live evidence under affirmation from the following witnesses called on behalf of the NMC:

- Colleague 1: Band 5 registered staff nurse working at the Hospital on Ward 4 alongside you at the time of some of the alleged incidents.

- Colleague 2: Band 7 senior sister at the Hospital on Ward 4 and your line manager at the time of some of the alleged incidents.

- Colleague 3: Band 6 nursing sister working at the Hospital on Ward 4. Provided cover for Colleague 2 and acted as your line manager in her absence at the time of some of the alleged incidents.

- Colleague 4: Critical Care Outreach Practitioner working at the Hospital and a witness to some of the alleged incidents.

- Colleague 5: Clinical Education Facilitator working at the Hospital and provided support and training to you at the time of the alleged concerns.

- Colleague 6: Registered staff nurse working alongside you at the Hospital on Ward 4 and present at the time of some of the alleged incidents.

- Colleague 7: Band 6 sister working alongside you at the Hospital on Ward 4 and present at the time of some of the alleged incidents.

- Ms 8: Band 8A Matron for Acute Medicine at the Hospital and Matron at the time of the alleged incidents.

The panel also heard live evidence under affirmation from the following witnesses called on your behalf:

- Ms 9: Staff Nurse currently working alongside you at Stepping Hill Hospital.

- Ms 10: Healthcare assistant currently working alongside you at Stepping Hill Hospital.

The panel also heard evidence from you under affirmation.

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 both the NMC and Ms Shah.

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

Charge 1

That you, a registered nurse, between 20 November 2017 and 17 July 2018 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 staff nurse in that you;

1) On one or more occasions in December 2017 and/or January 2018 incorrectly increased a patient's nasal cannula oxygen level to above 5 litres.

This charge is found proved.

In reaching this decision, the panel took into account that you had made a partial admission, in that you admitted that this had occurred on only one occasion in December 2017. The panel heard evidence from a number of witnesses who recalled you incorrectly increasing a patient's nasal cannula oxygen level to above five litres on one occasion in December 2017.

The panel considered the evidence of all of the relevant witnesses, and in particular your evidence and the evidence of Colleague 6 in reaching its decision as to whether this incident occurred on more than one occasion. The panel noted that apart from Colleague 6 there were no other witnesses with knowledge of a second incident where you had incorrectly increased a patient's nasal cannula oxygen levels to above five litres during this period. There was no record of a second incident occurring, no Datix and no report to your line manager or a nurse in charge.

The panel noted that Colleague 6 was clear in her evidence and did her best to assist the panel. However, Colleague 6 was unable to provide any specific details of a second incident, such as the date or name of the patient. Given the lack of detail and the absence of any corroborative evidence, the panel was not satisfied that a second incident had taken place during the period alleged.

Therefore, the panel finds this charge proved on only one occasion in December 2017 or January 2018.

Charge 3a

3) On 19 January 2018;

a) Did not feel for a manual pulse with patients.

This charge is found proved.

The panel noted that you made a partial admission to this charge in that you said that you did not feel for a manual pulse with one patient.

On 19 January 2018, Colleague 4, the critical outreach care nurse worked with you from 9am to 1pm. You said that you understood that the purpose of the session was to facilitate your learning and provide you with training on oxygen therapy. You said that you did not realise that you were being assessed on taking a manual pulse on a patient or that you had been asked to do this. You said you had listened to Colleague 4 and nodded in response to what she had said to you.

The panel noted that you had completed a Critical Care Outreach Reflection form before and after the session, which indicated what you wished to achieve with Colleague 4. In response to the question on the form '*What would you liked to achieve in the session with Outreach?'* you wrote *'Oxygen therapy to different patients. Assessment and plan care for critical in-patients.'*

In response to the question on the form '*What learning/understanding did your session with Outreach help you with?'* you wrote *'I learnt how do [sic] assess critically ill patients by ABCDE assessment tool. Planning patient care and manage patient condition… oxygen therapy. From this learning I have good understand [sic] my role in ward 4. '*

In her oral evidence, Colleague 4 told the panel that during the session with you, she had difficulties understanding you and was not sure whether you had understood her.

After the session, on 10 March 2018, Colleague 4 provided a summary of her observations of the session on 19 January 2019 to your Line Manager and your Matron.

In reaching its decision, the panel took into account in particular the evidence of Colleague 4 and your evidence. The panel noted that you and Colleague 4 had attended to three patients during the session. Colleague 4 was unable to confirm whether or not you felt for

a manual pulse with more than one patient. There is no corroborating evidence to assist the panel. The panel therefore cannot be satisfied on the balance of probabilities that you failed to feel for a manual pulse with more than one patient.

The panel therefore find this charge proved in relation to one patient only.

Charge 3b

3) On 19 January 2018;

b) Took an inaccurate oxygen saturation reading for a patient.

This charge is found proved.

In reaching its decision, the panel took into account in particular the witness evidence of Colleague 4 and your evidence.

You said that you had not taken an oxygen saturation reading for a patient. You recalled putting the oximeter on a patient's finger and you had waited for Colleague 4 to assess the patient. You said that Colleague 4 had talked 'non-stop' and you did not realise that you were being asked to take an oxygen saturation reading or that you were being assessed on this. You said that before that session on 19 January 2018 there had been no complaints about you not being able to take observations on patients.

The panel noted that the email written by Colleague 4, dated 10 March 2018, was a relatively contemporaneous documentary account of the session with you on 19 January 2018. It was also consistent with Colleague 4's written and live evidence. In her email dated 10 March 2018, Colleague 4 stated:

"She did not take a manual pulse to check for regularity or character, without being asked and took oxygen saturations from the number alone, without using the pulse

monitor bar, which can indicate the pulse behind the pulse oxymetry [sic]. For the first patient this meant the reading, heart rate and oxygen sats were incorrect."

The panel found Colleague 4's evidence to be clear and reliable and noted that she was an experienced nurse and trainer.

The panel was not provided with any other documentary evidence to support the charge that an inaccurate oxygen saturation reading was taken. However, the panel bore in the mind the context of this session, where you were being observed by Colleague 4. The panel was satisfied that based on the evidence before it, Colleague 4 had asked you to take an oxygen saturation reading of a patient during the session with her and that you did so inaccurately.

The panel was therefore satisfied that this charge is found proved.

Charge 3c

3) On 19 January 2018;

c) Were unable to explain how you could increase a patient's urine output or blood pressure through fluid input.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and the witness statement of Colleague 4, which was consistent with her oral evidence.

The panel noted that in your evidence you had stated that you were not asked any specific questions or asked to explain how you could increase a patient's urine output or blood pressure through fluid input. You said that you could explain had you been asked. The panel noted that the evidence before it pointed to some misunderstanding around the

purpose of the session and some difficulties in communication between you and Colleague 4.

In her email of 10 March 2018, Colleague 4 stated:

> *"Lisa was not able to tell me how a low fluid input might affect a patient's blood pressure, heart rate and urine output. Lisa was unable to tell me what nursing interventions she could employ to improve a patient's low blood pressure or low urine output."*

In her witness statement Colleague 4 said:

> *"I would expect all qualified nurses to have this understanding and be able to assess vital signs and fluid input and output chart finding and know what actions to take to optimise a patient's condition or escalate to senior staff when appropriate. Understanding the relationship between vital signs and fluid input/output, and act on the findings, is a basic nursing skill… Lisa was unable to communicate her understanding of this or how she might relate fluids and vital signs."*

The panel noted that the email dated 10 March 2018 was a relatively contemporaneous documentary account of the session on 19 January 2018. It was also consistent with Colleague 4's written and oral evidence, which the panel found clear and compelling. The panel accepted that you had no recollection of being asked specific questions on how you could increase a patient's urine output or blood pressure through fluid input. It was not clear whether this was due to the passage of time or whether you had not understood at the time what you were being asked. However, the panel was satisfied on the basis of the information provided by Colleague 4, which is supported by her email of 10 March 2018, that you had been asked during the session to explain how you could increase a patient's urine output or blood pressure through fluid input and were unable to do so.

The panel therefore finds this charge proved.

Charge 3d

3) On 19 January 2018;

d) Were unable to critically analyse patient observations.

This charge is found proved.

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

You told the panel that you were able to critically analyse patient observations, as you had worked as a registered nurse in China and the UK for many years. You said there had been no complaints about your patient observations before and since. You also told the panel that Colleague 4 had not asked you during the session, on 19 January 2018, to critically analyse patient observations.

Colleague 4 stated in her evidence that:

> *"I would have asked very basic questions and very limited basic knowledge on care, and building blocks were given… she did say I don't know and could not tell me."*

And:

> *"…In her verbal feedback I had little confidence that she was processing or linking the finding in patients, to the care and plans that were put in place."*

And:

"I observed she was unable to critically analyse patient observations at the most basic level."

The panel took account of all the evidence before it. It attached more weight to Colleague 4's evidence because it was supported by her written account on 10 March 2018 which was prepared relatively close to the session on 19 January 2018.

The panel also noted that charges 3a, 3b and 3c are intrinsically and clinically linked to charge 3d. The panel's findings in relation to charges 3a, 3b and 3c, together with the evidence of Colleague 4 leads the panel to conclude on the balance of probabilities that you were unable to critically analyse patient observations.

The panel therefore found this charge proved.

Charges 4b (i), (ii) and (iii)

4) On 1 February 2018;

b) Before putting a nasal cannula on a patient;

i. Did not check the patient's oxygen saturations

ii. Did not check the patient's oxygen prescription against the flow meter.

iii. Did not ensure the oxygen was connected.

These charges are found proved.

In reaching this decision, the panel took into account your evidence and the evidence of Colleague 5, who undertook an assessed supervised drug round with you on Ward 4 on 1 February 2018.

You had no recollection of this incident.

The panel had particular regard to Colleague 5's report dated 1 February 2018 to the Matron and your Line manager providing feedback on the assessment of the same date. In this contemporaneous report she stated:

> *"Further to the previous issues about oxygen administration, she put a pt's nasal cannulae back on that were on the bedside locker. However, the tubing wasn't connected to the wall and she did not realise as she had not checked the flow meter."*

The panel found that Colleague 5's recollection was supported by her contemporaneous report. Your position was that you had no recollection of these events charged. In these circumstances, the panel accepted the evidence of Colleague 5 and was satisfied on the balance of probabilities that the events occurred as described and finds these charges proved.

Charge 5a

5) On 7 February 2018 when completing a quiz on common drugs;

a) Struggled to identify common drugs.

This charge is found not proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Colleague 5.

The panel had regard to Colleague 5's NMC witness statement, in which she had stated:

"*I did a bespoke classroom training with Lisa which I had done before with staff members who faced difficulties in carrying out their roles. I do medicine management training for Internationally Educated Nurses so I used the same basis of training with Lisa. I started with a basic quiz of really common drugs and Lisa was asked to say the clinical indication for it and any pre-admission checks required. The test is aimed at the knowledge level of a newly qualified Staff Nurse and I have also successfully used it with Training Nursing Associates and Student Nurses.*

Normally this quiz takes about 10 to 15 minutes but Lisa and I had spent an hour and 40 minutes covering it. Lisa struggled to identify many of the common drugs listed. She was unable to pronounce many of the drugs as her English comprehension appeared to be extremely poor…".

Colleague 5's evidence was supported by her contemporaneous 'Summary Report' dated 8 February 2018, which stated that:

"*The initial activity today was to complete a basic drug quiz asking Lisa to indicate the actions of a sample range of medications and to describe any cautions, pre-administration checks… I was anticipating that this exercise would take approximately 10-15 minutes – I use it regularly with the International Nurses on their Induction Programme and it is based at the knowledge level of a newly qualified staff nurse. However, this exercise took from 1.00pm – 2.40pm.*

Lisa struggled to identify many of the common drugs listed. As identified last week, she is unable to pronounce many of the drugs as her English comprehension appears to be limited. She does not appear to understand the drug name that is written in front of her and tries to match the drug to either the box of medication she is holding or she looks at the Medicine Reconciliation information on the back of the drug chart".

In considering this charge, the panel noted that it had not been provided with clear evidence regarding what specific common drugs you struggled to identify. Colleague 5 told the panel that you had struggled to identify many of the common drugs listed in the quiz, but Colleague 5 could not identify what they were. Moreover, Colleague 5 was unable to assist the panel with which parts of the quiz worksheet you had completed independently and which parts were completed during her discussion with you following your completion of the quiz worksheet.

The panel took account of a copy of the quiz worksheet, provided by you that you said you had completed on 7 February 2018. You told the panel that you had completed the majority of the quiz worksheet prior to having had a discussion with Colleague 5.

In light of the above, the panel was not satisfied on the balance of probabilities that you had struggled to identify common drugs when completing a quiz on 7 February 2018.

The panel found charge 5a not proved.

Charges 5b (i) and (ii)

5) On 7 February 2018 when completing a quiz on common drugs;

b) In relation to amlodipine;

i. Could not state when it would be omitted.

ii. Could not state the safe threshold of administration based on a patient's blood pressure.

These charges are found not proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Colleague 5.

The panel had regard to Colleague 5's NMC witness statement, in which she had stated:

> "*One of the questions on that quiz was: What is Amlodipine (a calcium channel blocker used to treat angina/hypertension)? She correctly answered that it is used to treat hypertension but she could not state when she would omit the drug, or the safe threshold of administration based on the patient's blood pressure*".

The panel took account of the copy of the completed quiz worksheet that was provided by you. It noted within this that you had completed the section on Amlodipine and given information on what the drug was for and when it should and should not be given to patients. Although, it was not clear to the panel whether this information was written in the quiz worksheet before or after your discussion with Colleague 5, the panel was not satisfied that you could not state when Amlodipine would be omitted.

The panel had regard to Colleague 5's 'Summary Report' dated 8 February 2018. The panel noted that there was no mention in this report of you being asked to state what the safe threshold of administration based on a patient's blood pressure would be. The only comment in this report directed to Amlodipine states:

> "*For example, Amlodipine – I would expect her to have simply written "to check blood pressure and pulse*".

Although Colleague 5 in her evidence said that you had been unable to state what the safe threshold of administration based on a patient's blood pressure would be, this was not supported by her contemporaneous 'Summary Report.' The panel would have expected this to have been recorded in that report. In all the circumstances, the panel could not be satisfied on the balance of probabilities that, in relation to Amlodipine, you could not state what the safe threshold of administration based on a patient's blood pressure would be.

The panel therefore found charges 5b(i) and 5b(ii) not proved.

Charge 5c

5) On 7 February 2018 when completing a quiz on common drugs;

c) Did not know what the term “systolic” meant.

This charge is found proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Colleague 5.

The panel had regard to Colleague 5’s witness statement, in which she had stated:

> “*…Within that discussion we started talking about systolic blood pressure. Systolic blood pressure is the top figure of the blood pressure reading. It is a common term but Lisa stated that she did not know what the term systolic meant. She said she had never heard of it before and she took a notebook out of her pocket and wrote down the term systolic and diastolic*”.

The panel also noted that Colleague 5 had stated in the ‘Summary Report’ dated 8 February 2018 that:

> “*…I asked her to explain what systolic blood pressure would she look for before administering atenolol - she did not know what the term systolic meant and said that she had not heard of it. She took a notebook out of her pocket and wrote down the terms systolic and diastolic*”.

You told the panel that you were certain you knew what the word “*systolic*” meant, given that you had worked as a registered nurse in China and the UK for many years. You told the panel that you tended to use simple terminology such as “*low blood pressure*” instead of using the word “*systolic*” in order to help a patient understand. The panel noted from

your completed quiz worksheet that the word "*systolic*" had clearly been written on to this document along with an indication of what it means. Having carefully considered all the evidence, the panel was satisfied that Colleague 5 had to explain the term *"systolic"* to you as you did not know what it meant.

Therefore, the panel found charge 5c proved.

Charges 5d (i) and (ii)

5) On 7 February 2018 when completing a quiz on common drugs;

d) In relation to warfarin;

i. Incorrectly stated that it was used for high cholesterol.

ii. Did not know what "international normalised ratio/INR" is.

These charges are found not proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Colleague 5. You referred the panel to your completed quiz worksheet. You denied saying to Colleague 5 that Warfarin was used to treat high cholesterol.

The panel had regard to Colleague 5's witness statement, in which she stated:

> "*One of the drugs listed in the quiz is Warfarin. It is an anti-coagulant which is given normally at 18:00 in the evening. It is used to treat conditions such as an irregular heartbeat (Atrial Fibrillation), artificial heart valve, pulmonary embolism and after cerebrovascular accident. When I asked her about its use she said it was used for high cholesterol. It is a drug commonly used in her ward on a daily basis, if not daily then on a weekly basis.*

The administration of this drug is based on patients' INR (International Normalized Ratio) which is the clotting time ratio and it is very basic. Lisa did not understand anything about the INR. She did not seem to have the comprehension of what Warfarin is. She said she just gave the drug. She could not convey any simple interpretation of why this drug was given.

Lisa stated that she had never heard of the term INR before and said she just administered the drug as the doctor prescribed. A registered nurse has to understand why this medication is given and why the doctors may omit it if the clotting is prolonged.

I would expect Lisa to have a basic understanding of this medication. I would have expected her to understand what Warfarin is and to name two or three conditions for why it is given. A patient's INR can vary and should be checked to determine what the dose should be. I would expect any Registered Nurse to understand this process".

In Colleague 5's 'Summary Report' dated 8 February 2018, she stated:

"*Another drug on the list was Warfarin. I asked her to name a couple of conditions for which a patient may be receiving Warfarin – she stated "high cholesterol". I went on to discuss conditions such as AF, heart valve replacement, PE etc. I spent time explaining the difference between a high INR and a low INR – Lisa did not understand the difference. She said that she just gave Warfarin based on what had been prescribed by the doctor and did not know why this varied between patients other than 'patients' bodies are different'*".

The panel noted from your completed quiz worksheet that you have clearly written next to Warfarin "*make blood thin…prevent blood clotting*". There was no information on the completed quiz worksheet to suggest that you had incorrectly stated that Warfarin was

used to treat high cholesterol. The panel was not satisfied on the balance of probabilities that you had incorrectly stated that Warfarin was used for high cholesterol.

In relation to charge 5d(ii), the panel considered there to be insufficient evidence to demonstrate that you did not have an understanding of what an international normalised ratio/INR is. The panel noted that you wrote on the quiz worksheet "*If INR too low or too high – ask doctor for given dose.*" The panel is therefore not satisfied that based on all the information before it, that you did not know what 'International Normalised Ratio/ INR' was.

The panel therefore found charges 5d(i) and 5d(ii) not proved.

Charge 5e

5) On 7 February 2018 when completing a quiz on common drugs;

e) Stated that you would administer cyclizine prescribed to be taken every 8 hours to a patient 6 hours after the last administration.

This charge is found proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Colleague 5.

The panel had regard to Colleague 5's witness statement, in which she had stated:

> "*The sample prescription I wrote on the mock drug chart was for Cyclizine which can be given eight hours apart – I wrote the administration frequency of eight hours on the prescription. A mock drug chart is just a blank drug chart. I wrote on that chart exactly how Cyclizine would be prescribed so that I could show her what it would look like as an example and use it to simulate the process of checking the Five Rights.*

Cyclizine was written on the prescription so I stated that the patient had it at 07:00 but the patient had complained to her about feeling sick-again at 13:00. I asked her the direct question, would she give it, and she said yes she would. I advised that would not be an eight hour interval, it is only six hours. Giving any drug two hours earlier than its prescribed recommended interval can lead to drug toxicity. Overdosing of cyclizine can cause extreme drowsiness, confusion and agitation".

In Colleague 5's 'Summary Report' dated 8 February 2018, she stated:

"*I discussed anti-emetics with Lisa as Cyclizine was a further drug listed in the quiz. Lisa stated that it was for sickness but did not know the term anti-emetic – again she wrote it down in her notebook. I stated that Cyclizine could be given 8 hourly. To reinforce this information, I wrote on a sample drug chart a PRN Cyclizine prescription. I asked Lisa that if she was working a long day on Ward 4 and had given the patient Cyclizine at 0700 but the patient still felt sick at 1300 drug round, could she administer Cyclizine again. She counted 8 hours on her fingers and then said she would give it at 1300. I advised her that this would not be an 8 hour interval and would be 6 and therefore should not be given*".

The panel noted from your oral evidence that you accepted that you had initially answered this question incorrectly when you were asked by Colleague 5, as you were nervous and had incorrectly calculated the number of hours. However, you said that you realised your mistake and corrected your answer and said that you would give it after 8 hours. Colleague 5 said that it was not her recollection, that you had corrected your answer or realised your mistake.

The panel considered that Colleague 5's evidence on this matter was clear, consistent and supported by her contemporaneous 'Summary Report.'

Therefore, the panel was satisfied that you had stated to Colleague 5 that you would administer Cyclizine prescribed to be taken every 8 hours to a patient 6 hours after the last administration.

The panel found charge 5e proved.

Charge 10a and 10b

10) On 20 June 2018;

a) Allowed Patient D to be discharged with a cannula still in place.
b) Did not make adequate records in relation to Patient D's discharge.

These charges are found not proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Patient D's wife and Colleague 2.

The panel had regard to Colleague 2's witness statement, in which she had stated:

"*With respect to the incident with Patient D on 20 June 2018, the issue here was the patient was discharged with a cannula insitu which is not acceptable. The issue was brought to my attention when a Datix completed by* [...] *who I believe is a district nurse.* [The District Nurse] *received a phone call on 20 June 2018 from this patients' wife to say he had a needle left in his arm.* [The District Nurse] *visited the patient at home and found he still had a cannula in his left arm so she removed it… the patient's wife, also made an informal complaint to the Trust through PALS ("patient advice and liaison service") on 25 June 2018.*

The roster screen shot shows that Lisa was working a long day shift on 20 June 2018 as it states LD…The copy of the patient's prescription from that day bears

Lisa's signature and the nursing notes from that day show notes from Lisa. Lisa has just written 20 June 2018 and 3E which was the date and patient bed number but has not written anything else with respect to any care provided to the patient that day or with regards to his discharge from hospital…

As Lisa was looking after the patient on the day of his discharge, she had to make sure everything was done properly for his discharge. One of the things to check was that the patient had no cannulas in his arm. Lisa's documentation for that day is inadequate, and there was nothing documented and nothing to say whether or not the patient had his cannula removed prior to being discharged. I do recall receiving an email in July 2018 from customer care with the letter from…attached and I forwarded this email to all the nurses to make them aware of the complaint and highlighted the importance of safe discharges. I also recall notifying [Ms 8] of this complaint as I had, by then, realised Lisa was the nurse looking after Patient D on the date in question. [Ms 8] and I had already met with Lisa on 26 June 2018 and we were due to meet with her again on 17 July 2018 so this would have been discussed with Lisa at that next meeting. However, the meeting on 17 July 2018 did not go ahead due to another incident which occurred that day…"

The panel also had sight of the letter from Patient D's wife dated 25 June 2018 which supports the assertion that she had reported this incident to the Hospital through PALS. Patient D's wife stated in her letter:

"*A thorough check should have taken place to make sure he was not sent home with cannula still attached to his arm. I had to contact his Medical Centre and have had district nurses in as there is concern about his arm now showing all the signs of phlebitis…*"

The panel noted that a District Nurse had to visit Patient D at his home in order to remove the cannula and that a Datix dated 20 September 2018 was completed by the District

Nurse in respect of this. The panel was satisfied from all the evidence that Patient D had been discharged with a cannula still in place.

The panel also noted that it had been provided with the redacted copies of Patient D's nursing notes and a copy of a prescription purporting to belong to him, albeit there was no name on this prescription for identification purposes.

The panel took account of your evidence. You accepted that you were looking after Patient D on the day of his discharge from the Hospital. However, you told the panel that you were off the ward for approximately an hour and a half, during which time, Patient D was discharged. You told the panel that you had no involvement with Patient D's discharge, and stated that upon returning to the ward, Patient D had already left and his nursing notes had been removed from the ward.

The panel also took account of the record of the telephone call between Patient D's wife and the District Nurse who attended Patient D. This states that the *"…eDNF was signed off by the discharge support worker.*" The Investigation Report completed in response to the District Nurse's Datix dated 20 September 2018 also did not identify you as the discharging nurse.

Having carefully reviewed all of the evidence before it, the panel was not satisfied that, on the balance of probabilities, you were present on the ward at the time Patient D was discharged from the Hospital, that you had discharged Patient D or that you had allowed him to be discharged with a cannula still in place.

In relation to charge 10b and in the context of its decision above in charge 10a, the panel determined that there would not have been an obligation on you to complete records in relation to Patient D's discharge as you were not the discharging nurse. The panel accepted your explanation that when you returned to the ward, Patient D had been discharged and his medical records had been removed from the ward.

The panel found charges 10a and 10b not proved.

Charge 11

> 11) In or around July 2018 incorrectly removed a patient's Hi Flow oxygen nasal cannula to administer a nebuliser.

This charge is found not proved.

In reaching this decision, the panel took account of all the relevant evidence, in particular your evidence and the evidence of Colleague 6. You denied this charge.

The panel had regard to Colleague 6's witness statement, in which she had stated:

> "*This incident happened shortly before Lisa left the Trust. It was a day shift. I was not the nurse in charge but the incident was noticed by me. Lisa removed the nasal cannula Hi Flow oxygen that the patient was on and put her on the nebuliser. […] The reason I came across the patient is because when we have a level 2 patient on oxygen therapy, the nurse in charge is aware of such patient and regularly checks on them which is what I was doing. Level 2 patients are those patients who require more specific and specialised care. I was not the nurse in charge but kept an eye on level 2 patients. […] I immediately removed the mask and put the patient back on the oxygen via nasal cannula. […]*
>
> *I did not speak to Lisa there and then. Afterwards, I asked Lisa why she did what she did and was she not aware of how we do things…*"

In considering this charge, the panel noted that Colleague 6 was the only person that recalled an incident in July 2018 where you had incorrectly removed a patient's Hi Flow oxygen nasal cannula. The only evidence provided to the panel to support this charge was

Colleague 6's evidence. The panel did not see evidence of a Datix recording this incident or evidence that it had been escalated to the nurse in charge or your line manager.

Given the lack of any corroborative evidence to support Colleague 6's account, the panel was not satisfied that this was a separate incident involving oxygen therapy from that set out in the charges. Therefore, the panel was not satisfied that in or around July 2018, you incorrectly removed a patient's Hi Flow oxygen nasal cannula to administer a nebuliser.

The panel therefore found charge 11 not proved.

Charge 12a

12) On 17 July 2018, in relation to Patient E;

a) Changed the oxygen level when Colleague 2 had told you not to do so.

This charge is found proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Colleagues 2 and 7.

You told the panel that Colleague 2 told you to change Patient E's oxygen and Colleague 2 did not tell you to wait for her to do this. Furthermore, you said that following the incident with Patient E you had argued with Colleague 2 and strongly rejected that she had told you to wait to change the oxygen levels.

The panel had regard to Colleague 2's witness statement, in which she had stated:

"*At 11:00 Lisa came into the office where I was working at one computer and*

Catherine was working at the other computer. Lisa asked [Colleague 7] to give Patient E some morphine with her before she went for her break. Lisa also asked me about changing Patient E's oxygen, I advised her to give the morphine then to go for her break and not to worry about Patient E's oxygen, that I would make the changes to his oxygen later on in the afternoon once all his family had visited as there was no rush with this. [Colleague 7] and Lisa left the office and gave some morphine at 11:00".

The panel also had regard to Colleague 7's witness statement, in which she had stated:

"*Lisa came to me again at 11 am. She wanted to ask how to convert a patient from nasal high flow to normal nasal cannula oxygen at with low flow and I talked her through how to do it. We then went to the machine and showed her physically how to do it. At this point, I asked Lisa "have you weaned him?" Lisa said yes. While I was there we converted the patient onto nasal cannula, we competed this together an I had to show Lisa how to remove the nasal high flow oxygen port from the wall as she was struggling to do so, and replace with a regular oxygen port, she stated that she had struggled earlier to remove the oxygen port and this is why she had asked for my help, the patient was changed to nasal cannula Lisa was then ok so I returned to my patients.*

When a patient is on nasal high flow oxygen, if we change the oxygen supply from 100% to nasal cannula (range of 21-40%) without flow it is a big difference so we wean them down slowly and then convert them onto nasal cannula. This patient had turned palliative, and the nasal high flow is warm, it helps keep the airways open and moist we were switching him to a less invasive way of delivering oxygen. In response to my question Lisa told me she had weaned him down. In order to wean down a patient, you press the button on the nasal high flow machine to reduce the flow rate down and decrease the flow on the oxygen meter. When Lisa and I went to the machine, the ball on the oxygen flow meter ball was at its lowest so it looked like Lisa had weaned the patient down. Then Lisa and I converted the

patient to normal oxygen on nasal cannula, at its highest % and I then continued with my other tasks.

A bit later Lisa came to [Colleague 2] in the ward office in a bit of a panic. I was also present in the office at this time. Lisa told [Colleague 2] that the nasal high flow wasn't working and she had taken it away from the bedside as the machine wasn't working [Colleague 2] left the office to check on the patient's condition and to help Lisa. It is my understanding that the patient wasn't on any oxygen when Lisa came to find us, Lisa had put the nasal cannula back on the patient's nose but she not checked to see it was connected to the oxygen portl [sic]. *[Colleague 2] told me the patient was close to end of life, so he deteriorated potentially quicker than he would have. Once [Colleague 2] had attended to the patient we checked the nasal high flow and set it up and found that it was working.*"

In her oral evidence, Colleague 2 stated that she had given you very clear instructions that you should wait for her to assist with changing the oxygen levels of Patient E. Colleague 7 told the panel that she was not present at this point so she was unable to confirm what specific instructions Colleague 2 had given to you.

In considering all of the evidence before it, the panel was satisfied that it is more likely than not that you were told to wait for Colleague 2 to return to assist you in changing Patient E's oxygen levels.

As your line manager, Colleague 2 was aware of previous issues you had had with oxygen therapy. The panel was satisfied that Colleague 2 wanted to ensure that you were supported in successfully completing this task of changing Patient E's oxygen levels. The panel was satisfied that you were told to wait, that there was no rush to carry out this task as Patient E was end of life and his family was still expected to come and say their goodbyes.

The panel does not consider that you deliberately ignored the instructions of Colleague 2. Given the underlying concerns around your understanding and use of the English language, the panel determined that it was more likely that you misunderstood what was being asked of you.

The panel was satisfied that on 17 July 2018, you changed the oxygen level for Patient E when Colleague 2 had told you not to do so.

The panel found charge 12a proved.

Charge 12b

12) On 17 July 2018, in relation to Patient E;

b) Did not wean Patient E's oxygen adequately or at all before converting from Hi Flow to nasal cannula.

This charge is found proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Colleague 7.

You made a partial admission to this charge, in that you accepted that you did not wean Patient E's oxygen adequately. You said that you recognised that you had weaned Patient E too quickly.

The panel had regard to Colleague 7's witness statement, in which she had stated:

"*At this point, I asked Lisa "have you weaned him?" Lisa said yes. While I was there we converted the patient onto nasal cannula, we competed this together an I had to show Lisa how to remove the nasal high flow oxygen port from the wall as she was*

struggling to do so, and replace with a regular oxygen port, she stated that she had struggled earlier to remove the oxygen port and this is why she had asked for my help, the patient was changed to nasal cannula Lisa was then ok so I returned to my patients.

…In response to my question Lisa told me she had weaned him down. In order to wean down a patient, you press the button on the nasal high flow machine to reduce the flow rate down and decrease the flow on the oxygen meter. When Lisa and I went to the machine, the ball on the oxygen flow meter ball was at its lowest so it looked like Lisa had weaned the patient down. Then Lisa and I converted the patient to normal oxygen on nasal cannula, at its highest % and I then continued with my other tasks...

When a patient is on nasal high flow, as this patient was, who required weaning I normally would complete this gradually taking the day or longer depending upon the patients comfort/oxygen saturation levels, reducing both the flow and the oxygen concentration, as if you complete a quick wean, you aren't given the patient a chance to accommodate that there is no flow there...".

The panel was satisfied, on the basis of your admission and Colleague 7's evidence, that you did wean Patient E's oxygen, however that you failed to do this adequately before converting Patient E from Hi Flow to nasal cannula.

Therefore, the panel found charge 12b proved.

Charge 12c

12) On 17 July 2018, in relation to Patient E;

c) Did not connect the nasal cannula to the low flow oxygen meter.

This charge is found not proved.

In reaching this decision, the panel took account of your evidence, as well as the evidence of Colleague 7.

The panel noted from the evidence before it that both you and Colleague 7 confirm that you changed the nasal cannula for Patient E at around 11am and that this had been connected to the low flow oxygen meter. Colleague 7 told the panel that after the nasal cannula was changed everything was working as it should have been.

Colleague 7 wrote in her statement following the incident:

> "*Lisa later asked if I could help her with giving a patient some diamorphine at 11am before she went for break, which we completed together, whilst we were at the patient's bedside she asked how to remove the 02 port from the wall for the nasal high flow as she wanted to put a double 02 port in its place as she was converting the gentleman to nasal cannula 02 for comfort as he was now on the end of life pathway…I changed the 02 port after I had checked that this was the plan and that she had weaned down the nasal humidified she said "yes", Lisa then connected the gentleman to the nasal cannula at 41 and, at this point the patients family were with him and he looked comfortable…*"

The panel was satisfied, on the basis of your evidence and the evidence of Colleague 7, that you did connect the nasal cannula to the low flow oxygen meter for Patient E.

The panel therefore found charge 12c not proved.

Charge 13

13) Do not have the necessary knowledge of English to practise safely and effectively.

This charge is found proved.

In reaching this decision, the panel took account of your evidence, the evidence of the witnesses (both of the NMC and those called by you) and the documentary evidence, including the results of your English Language tests. The panel also took into account the NMC's guidance on language requirements and in particular the criteria for assessing language competence.

You provided the panel with the results of an IELTS examination you took on 8 December 2018. You received an overall score of 5.5, which is below the minimum score of 7 required by the NMC. The panel noted that you did not achieve the minimum score required by the NMC in any of the individual categories of reading, writing, listening and speaking in that test. You also provided the panel with the results of an OET examination you took in May 2021 where you achieved an overall score of C. The panel noted that you failed to reach the overall minimum score of B, required by the NMC.

The panel noted that you qualified as a nurse in the UK after completing an honours degree in nursing at University of Salford in 2016. The panel noted that you had worked as a nurse for approximately a year before joining as a Band 5 nurse on Ward 4 at the Hospital in November 2017. Following your resignation from Ward 4 in July 2018, you told the panel that you are now employed as a nurse at Stepping Hill Hospital.

The panel took into account the evidence of all the witnesses, including those from your current place of work at Stepping Hill Hospital. Whilst both your witnesses attested to

being able to understand you, they confirmed that you sometimes spoke faster on occasions and they had to ask you to repeat yourself when you get "*excited.*"

The panel noted that eight witnesses had been called on behalf of the NMC, the majority of whom confirmed that they had found you difficult to understand during your period of employment at the Hospital, between November 2017 and July 2018. One colleague said she was able to understand you, however she said you became harder to understand when you were visibly distressed or anxious.

Notwithstanding that you that you qualified as a registered nurse in the UK and worked for over a year as a nurse in the UK, you have not been able to demonstrate, through the accepted English language tests, that you have met the standard required by the NMC, to practise safely and effectively as a registered nurse.

Therefore, taking into account all the evidence before it, the panel determined that you do not have the necessary knowledge of English to practise safely and effectively as a registered nurse.

The panel found charge 13 proved.

Interim order

Due to insufficient time, the panel was not in a position to hand down its decision on impairment. The panel therefore invited both parties to make submissions on the current interim order.

Mr Edwards submitted that the current interim order remains necessary and appropriate taking into account the facts found proved by the panel. He submitted that, given that you have practised as a registered nurse for over three years, a more restrictive order was not necessary.

Ms Shah also submitted that the current order remains necessary but she invited the panel to consider removing interim condition 2 as you have now addressed these concerns and have practised as a registered nurse for over three years without incident.

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

Having heard from both parties and having considered the facts found proved, the panel was satisfied that the current interim order remains necessary on both public protection and wider public interest grounds.

This will be confirmed to you in writing.

That concludes this determination.