# Nursing and Midwifery Council
# Fitness to Practise Committee

## Substantive Hearing
## Monday 7 March 2022 – Thursday 10 March 2022

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

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| **Name of registrant:** | **Elita Matri Sibanda** |
| **NMC PIN:** | 08B0338E |
| **Part(s) of the register:** | Registered Nurse - Sub Part one<br>RNA: Adult Nurse - November 2008 |
| **Area of registered address:** | Kent |
| **Type of case:** | Misconduct |
| **Panel members:** | Deborah Jones (Chair, Lay member)<br>Margaret Marshall (Registrant member)<br>Tricia Breslin (Lay member) |
| **Legal Assessor:** | Mark Ruffell |
| **Hearings Coordinator:** | Sherica Dosunmu |
| **Nursing and Midwifery Council:** | Represented by Kate Hare, Case Presenter |
| **Mrs Sibanda:** | Present and unrepresented |
| **Facts proved by admission:** | Charges 1a, 1b |
| **Facts proved:** | All |
| **Facts not proved:** | N/A |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Suspension (12 months) with a review** |
| **Interim order:** | **Interim suspension order (18 months)** |

**Decision and reasons on application to admit the hearsay evidence of Resident A**

At the outset of the hearing Ms Hare, on behalf of the Nursing and Midwifery Council (NMC), informed the panel that within Colleague C's written witness statement, in one paragraph, Colleague C explains what Resident A said to her on 7 April 2019. Resident A was not present at this hearing. Ms Hare stated that she understood that this would be classified as hearsay evidence.

Ms Hare made an application under Rule 31 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules) to allow the paragraph referring to what was said by Resident A to Colleague C to be admitted into evidence. Ms Hare submitted that the hearsay evidence is both fair and relevant to be admitted.

You indicated that you do not object to the admission of Resident A's hearsay evidence.

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

The panel gave the application in regard to Resident A's hearsay evidence serious consideration. The panel was satisfied that the evidence was relevant to the circumstances in which the events on 5 April 2019, relating to charges 1a and 1b, took place. The panel considered whether you would be disadvantaged by the hearsay evidence. The panel considered that the evidence is not the sole or decisive evidence in support of any of the charges and it took into account that you did not oppose the application. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel determined that it would be fair and relevant to admit Resident A's hearsay evidence.

**Details of charge**

That you, a registered nurse:

1) On 5 April 2019, did not administer Amoxicillin 250mg capsules to Resident A as prescribed at:

    a) 08:00, [PROVED BY ADMISSION]
    b) 15:30. [PROVED BY ADMISSION]

2) On or around 6 April 2019:

    a) Retrospectively recorded “O + D” on Resident A’s MAR chart for the following entries:
        i) 5 April 2019 at 08:00, [FOUND PROVED]
        ii) 5 April 2019 at 15:30; [FOUND PROVED]

    b) Retrospectively recorded medication stock running totals on Resident A’s MAR chart to read:
        i) “12” for 5 April 2019 at 08:00, [FOUND PROVED]
        ii) “11” for 5 April 2019 at 15:30; [FOUND PROVED]

    c) Retrospectively record on the reverse of the MAR chart:
        i) “05/04/2019 08:00 Amoxicillin 250mg cap not taken, patient having difficult [sic] to swallow capsule”, [FOUND PROVED]
        ii) “05/04/2019 15:30 Amoxicillin 250mg caps not taken, patient having difficult [sic] to swallow capsule”; [FOUND PROVED]

    d) Did not record that the amendments mentioned in the following charges were made retrospectively:
        i) Charges 2(a), [FOUND PROVED]

ii) Charges 2(b), [FOUND PROVED]
iii) Charges 2(c); [FOUND PROVED]

e) Amended the stock running total for colleague B's entry on 5 April 2019 at 22:00 from "12" to "10"; [FOUND PROVED]

f) Did not indicate on the MAR that you amended the record as set out in charge 2(e). [FOUND PROVED]

3) Your actions in charge 2 above were dishonest in that you intended to create the impression that you had correctly recorded your omissions to administer Resident A's medication when you had not. [FOUND PROVED]

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

**Background**

The NMC received a referral on 10 May 2019 in relation to concerns raised while you were working at Henry Nihill House (the Home) as a Registered Nurse through Open 24 Health Care Recruiters (the Agency).

The referral alleges that on 5 April 2019, while working at the Home on a day shift, you failed to administer antibiotic medication (Amoxicillin) to Resident A at 08:00 and 15:30. Resident A began a course of antibiotics for chest infection on 4 April 2019. It is alleged that during your day shift on 6 April 2019, these omissions were brought to your attention and that you subsequently amended the Medication Administration Record (MAR) chart to indicate that you had made unsuccessful efforts to administer the medication to the resident on 5 April 2019, but failed to mark this as a retrospective entry. It is alleged that you also made adjustments to the medication stock balance.

The Home's Registered Manager, Colleague C, was informed of the concerns on 7 April 2019. She undertook an investigation and contacted Mr 1 at the Agency, requesting a statement from you by 12:00 on 8 April 2019. You supplied a statement to the Agency on 17 April 2019, in which you explained that the medication was not administered on 5 April 2019 at 08:00 and 15:30 as Resident A had difficulty with swallowing, and that you had recorded this on the MAR chart on 5 April 2019 including the reason for the medication not being administered. You denied any retrospective recording on the MAR chart.

The Home reported these concerns to the Care Quality Commission (CQC) and local safeguarding teams.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

- Colleague B: Employed Staff Nurse at the Home;

- Colleague A: Agency Staff Nurse at the Home;

The evidence from Colleague C, Registered Manager of the Home; and Mr 1, Office Manager of the Agency were read into evidence.

The panel also heard evidence from you under affirmation and the panel noted that your evidence has remained consistent at this hearing and throughout the previous investigations.

**Decision and reasons on facts**

At the outset of the hearing, you informed the panel that you admitted to charges 1a and 1b. Therefore, the panel found charges 1a and 1b proved by way of your admissions.

Ms Hare, on behalf of the NMC, invited the panel to consider why you failed to administer the Amoxicillin capsules to Resident A as referred to in charges 1a and 1b. Ms Hare submitted that the evidence suggests you failed to do so as you simply forgot to during a busy shift. She submitted that considering the reason why you failed to administer the Amoxicillin capsules to Resident A will create context for charge 2 and its sub charges.

The panel therefore reviewed all the evidence adduced in this case relating to charges 1a and 1b. The panel noted that in your evidence you stated that you failed to administer the Amoxicillin capsules as Resident A had difficulty with swallowing and you were not aware of how to administer medication to the resident. The panel considered Colleague A's written statement:

> *'She [Resident A] said that she had always found tablets difficult to swallow since she was a child and she took them with a banana. I asked her if she had any*

*difficulty with her antibiotic and she said she hadn't and had managed to take them on each occasion.'*

The panel noted Resident A's Care Plan, which indicates the resident's assessment needs, in which it is stated:

'*I take my medication with a fruit preferably banana and a glass of water'.*

The panel also took into account Resident A's MAR chart, which shows that the antibiotics were successfully administered on all occasions other than 08:00 and 15:30 on 5 April 2019.

The panel bore in mind Colleague C's written statement where Resident A explained on 7 April 2019 that she had managed to take the medication on each occasion it was given to her. The panel was therefore of the view that on the balance of probabilities, it is more likely than not that staff including yourself would have been aware that Resident A had difficulty with swallowing capsules and required the assistance of food to take such medication. The panel therefore did not accept your account that you were not aware of how medication should be administered to Resident A.

The panel noted that in your oral evidence you stated that at the time of the events in charge 1, you suggested to Colleague A that Resident A required covert administration of medication. The panel accepted Colleague A's explanation of covert medication in her oral evidence, in which she explained that this is the medical decision to hide medication in food in a situation where a patient refuses the medication but their right is overridden by medical necessity. The panel was of the view that the evidence before it indicated that Resident A was aware of medication being administered to her, however preferred this to be administered in food. It found no evidence that covert administration of medication was ever required for Resident A.

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 Hare and those made by you.

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

**Charge 2**

2) On or around 6 April 2019:

a) Retrospectively recorded "O + D" on Resident A's MAR chart for the following entries:
i) 5 April 2019 at 08:00,
ii) 5 April 2019 at 15:30.

b) Retrospectively recorded medication stock running totals on Resident A's MAR chart to read:
i) "12" for 5 April 2019 at 08:00,
iii) "11" for 5 April 2019 at 15:30;

c) Retrospectively record on the reverse of the MAR chart:
i) "05/04/2019 08:00 Amoxicillin 250mg cap not taken, patient having difficult [sic] to swallow capsule",
ii) "05/04/2019 15:30 Amoxicillin 250mg caps not taken, patient having difficult [sic] to swallow capsule";

d) Did not record that the amendments mentioned in the following charges were made retrospectively:
i) Charges 2(a),
ii) Charges 2(b),
iv) Charges 2(c);

e) Amended the stock running total for colleague B's entry on 5 April 2019 at 22:00 from "12" to "10";

f) Did not indicate on the MAR that you amended the record as set out in charge 2(e).

**This charge is found proved in its entirety.**

In reaching this decision, the panel took into account the evidence of Colleague A, Colleague B and Colleague C; as well as your oral evidence. The panel also considered the documentary evidence exhibited for Resident A, which included Resident A's MAR chart.

**2a) Retrospectively recorded "O + D" on Resident A's MAR chart for the following entries:**

**i) 5 April 2019 at 08:00,**

**ii) 5 April 2019 at 15:30.**

In relation to charge 2a(i) and (ii), the panel noted the following evidence from Colleague B indicating that you did not record any entries on Resident A's MAR chart by the end of your shift on 5 April 2019, in which she states:

*'About 2200 hours on Friday 5th April I was giving the resident A her medication and I noticed that there were 13 antibiotic capsules in her pack. I didn't think this was correct as there should have been 11 capsules in the pack if she had been given*

*her medication as required. I also noted that the MAR chart was not signed at 0800 hours and 1530 hours that day. I gave A her dose for 2200 hours and recorded the balance as 12 capsules on the MAR chart.'*

The panel also noted Colleague A's evidence, which also indicates that you did not record any entries on Resident A's MAR chart on 5 April 2019:

*'At the start of the shift the night Staff Nurse, Colleague B, told me that I should remind Elita to give the resident, Resident A, her antibiotics. When she handed over to me she informed me that last night (Friday 5th) the balance of Resident A antibiotic was 12 capsules instead of 10, which it should have been. We both then checked the MAR chart and it wasn't signed for the dose to be given at 0800 and 1530. The sections on the MAR chart were blank at this point. I checked the tablet balance and it was 12 at this point.'*

The panel considered that both Colleague B and Colleague A were consistent in indicating that they checked Resident A's MAR chart after you finished your shift on 5 April 2019.

The panel noted that you have stated in your oral evidence that you completed Resident A's MAR chart on the 5 April 2019 on both occasions when you attempted to administer the medication (at 08:00 and 15:30). The panel accepted Colleague B and Colleague A's evidence that you did not record the entries on the 5 April 2019.

The panel further noted that Colleague B and Colleague A also counted Resident A's medication stock and confirmed that the medication had not been given.

Colleague B stated:

*'I came into work 2100 hours on Saturday 6th April, as usual, however, did not see Elita to speak with her. At around 2200 I was preparing to give A her medication when I observed that the MAR chart was completed at 0800hours and 1530 hours*

*on Friday 5th April, with the abbreviation O + D written in the boxes. The balance at 2200 had also been amended from 12 to 10. At this point I checked and counted the capsules, noting that the balance was 8 instead of 10.*

*The O + D abbreviations means Other and Destroyed. I also noticed it was recorded on the rear of the MAR chart that the capsules for 0800 hours and 1530 hours had not been taken and recorded was "patient having difficult to swallow capsule"". There was a signature recorded and it appeared to be that of Elita. The only entries I recorded on the MAR was my initials for 2200 hours medication and a medication count at 2200 hours on 5th April.'*

Colleague A stated:

*'When Elita came on shift at 0830 I spoke with her and told her it was noted that Resident A antibiotic capsules at 0800 and 1530 were not given. I showed her the MAR chart and the box of antibiotics and reminded her to give todays dose, which she replied 'okay'.*

*At about 1000 that morning I spoke with Elita to check if she needed any support with the medication administration but she informed me that she didn't. I again reminded her about Resident A antibiotic and she said she had given it. I then went to see Resident A and she informed me that she had taken it.*

*Later in that shift Elita told me that Resident A should be on covert medication because she had difficulty swallowing her capsule. I told her that this wasn't something that we done. She said that she had been made aware from her care plan that she prefers having capsules with fruit, such as banana, grapes or a yogurt. I explained to her that covert means hiding the capsule so she doesn't know it's there and asked Elita if she thought we should be hiding her tablet. She mumbled something in reply but I am not sure what she said.*

*When I came on shift the following morning, Sunday 7th April, I spoke with [Colleague B], who was finishing her night shift. She informed me that the balance for Resident A antibiotic capsules was 7 when it should have been 9, the MAR chart on 5th April at 0800 and 1530 had a record on it and the writing balance 2200 on the Friday 5th was changed from 12 to 10 capsules. The entry for the 5th was O & D, which means other and destroyed, and the details of these entries were written on the back by Elita. She wrote that the capsule was not taken as the patient had difficulty swallowing it. This isn't the case though. These entries were not present on the MAR chart the previous day and I believe were not written at those times.'*

The panel had regard to its reasoning in charge 1a and 1b and determined that, on the balance of probabilities, you did not record '*O + D*' on Resident A's MAR chart (for the 08:00 and 15:30 doses) on 5 April 2019.

The panel bore in mind that Colleague B had never met you prior to the events on 5 April 2019 and Colleague A had only worked with you for two or three shifts from her memory. The panel was therefore satisfied that neither witnesses would have had any reason or motivation to falsify their evidence indicating that you had not recorded entries on Resident A's MAR chart by the end of your shift on 5 April 2019.

Colleague B and Colleague A's concerns about the retrospective entries were escalated to the Home's Registered Manager, Colleague C. Colleague C stated:

'*I first became aware of the incident concerning Elita on Sunday 7th April 2019 when I was telephoned at home from the shift leader [Colleague A]. She informed me that she had found that Elita had omitted to administer two doses of amoxicillin, Resident A's antibiotic, on Friday 5th April at 0800 and 1530. This was found by [Colleague B], the night shift nurse, when she went to give the 2200 dose. She informed me that the number of capsules that was left showed that they had not been dispensed from the blister pack in the box. She then said that Elita was*

*reminded on Saturday morning to give the antibiotics and they were given correctly, however, that evening it was found that the number of tablets in the box were not correct and the MAR chart record had been changed.'*

In your evidence you confirmed that you were on duty on the morning of 6 April 2019. The panel therefore determined that you had the opportunity and motivation to amend Resident A's MAR chart retrospectively, which is supported by the evidence of Colleague B and Colleague A, who identified the entries completed on 6 April 2019.

The panel therefore finds charge 2a(i) and (ii) proved.

**2b) Retrospectively recorded medication stock running totals on Resident A's MAR chart to read:**

**i) "12" for 5 April 2019 at 08:00,**

**ii) "11" for 5 April 2019 at 15:30.**

In relation to charge 2b(i) and (ii), the panel had regard to its reasoning in charge 2a(i) and (ii). It accepted the evidence of Colleague B and Colleague A, which indicates that you did not record any entries on Resident A's MAR chart on 5 April 2019, but did so retrospectively on 6 April 2019. The panel also accepted their evidence with regard to the quantity of tablets they had counted.

For all the reasons given in charge 2a(i) and (ii), the panel concluded that you also retrospectively recorded medication stock running totals on Resident A's MAR chart to verify the omission you recorded on 6 April 2019.

The panel therefore finds charge 2b(i) and (ii) proved.

**2c) Retrospectively record on the reverse of the MAR chart:**

**i) "05/04/2019 08:00 Amoxicillin 250mg cap not taken, patient having difficult [sic] to swallow capsule",**

**ii) "05/04/2019 15:30 Amoxicillin 250mg caps not taken, patient having difficult [sic] to swallow capsule".**

In relation to charge 2c(i) and (ii), the panel had regard to its reasoning in charge 2a(i) and (ii). It accepted the evidence of Colleague B and Colleague A, which indicates that you did not record any entries on Resident A's MAR chart on 5 April 2019, but did so retrospectively on 6 April 2019.

For all the reasons given in charge 2a(i) and (ii), the panel concluded that you retrospectively recorded on the reverse of Resident A's MAR chart '*05/04/2019 08:00 Amoxicillin 250mg cap not taken, patient having difficult [sic] to swallow capsule*" and "*05/04/2019 15:30 Amoxicillin 250mg caps not taken, patient having difficult [sic] to swallow capsule*', in order to verify the omission you recorded on 6 April 2019.

The panel therefore finds charge 2c(i) and (ii) proved.

**2d) Did not record that the amendments mentioned in the following charges were made retrospectively:**

**i) Charges 2(a),**
**ii) Charges 2(b),**
**iii) Charges 2(c).**

In relation to charges 2d(i), (ii) and (iii), the panel had regard to its reasoning in charge 2a(i) and (ii). It accepted the evidence of Colleague B and Colleague A, which indicates that you did not record any entries on Resident A's MAR chart on 5 April 2019, but retrospectively on 6 April 2019.

The panel had particular regard to your oral evidence, in which you stated that if an omission is made it should be recorded and escalated. You accepted in your oral evidence

that your omissions were not escalated by yourself, but maintained that they were recorded at the time.

The panel, having already determined that the entries were made retrospectively, could find no evidence on Resident A's MAR chart to indicate this, as would have been required.

The panel therefore finds charge 2d(i), (ii) and (iii) proved.

**2e) Amended the stock running total for colleague B's entry on 5 April 2019 at 22:00 from "12" to "10".**

In relation to charge 2e, the panel had regard to its reasoning in charge 2a(i) and (ii). It accepted the evidence of Colleague B and Colleague A, which indicates that you did not record any entries on Resident A's MAR chart on 5 April 2019, but did so retrospectively on 6 April 2019.

The panel noted Resident A's MAR chart and accepted that this entry appears to have been amended.

For all the reasons given in charge 2a(i) and (ii), the panel concluded that, on the balance of probabilities, you also amended the stock running total for Colleague B's entry on 5 April 2019 at 22:00 from "12" to "10" to verify the omission you recorded on 6 April 2019.

The panel therefore finds charge 2e proved.

**2f) Did not indicate on the MAR that you amended the record as set out in charge 2(e).**

In relation to charge 2f, the panel had regard to its reasoning in charge 2a(i) and (ii). It accepted the evidence of Colleague B and Colleague A, which indicates that you did not

record any entries on Resident A's MAR chart on 5 April 2019, but did so retrospectively on 6 April 2019.

The panel, having already noted that the entry was amended could find no evidence on Resident A's MAR chart to indicate this, as would have been required.

For all the reasons given in charge 2a(i) and (ii), the panel concluded that, on the balance of probabilities, you did not provide any information to indicate you had made amendments, as the amendments were made to verify the omission you recorded on 6 April 2019.

The panel therefore finds charge 2e proved.

**Charge 3**

> 3) Your actions in charge 2 above were dishonest in that you intended to create the impression that you had correctly recorded your omissions to administer Resident A's medication when you had not.

**This charge is found proved.**

In reaching this decision, the panel took into account the evidence of Colleague B and Colleague A; as well as your oral evidence. The panel also considered the documentary evidence exhibited for Resident A, which included Resident A's MAR chart.

The panel applied the legal test for dishonesty and referred to the case of *Ivey v Genting Casinos* [2017] UKSC 67. In relation to charge 3, the panel considered whether you intended to create the impression that you had correctly recorded your omissions to administer Resident A's medication and; whether you were dishonest in doing so. The panel had regard to its reasoning in charge 2, in which it found that you retrospectively

recorded your entries and altered the medication stock balance in Resident A's MAR chart on 6 April 2019.

The panel determined that it saw no reason to doubt Colleague B and Colleague A's concerns about the retrospective entries as these were escalated to the Home's Registered Manager, Colleague C.

The panel noted that the omissions were brought to your attention by Colleague A on the morning of 6 April 2019:

> *'When Elita came on shift at 08:30 I spoke with her and told her it was noted that Resident A antibiotic capsules at 08:00 and 15:30 were not given. I also showed her the MAR chart and the box of antibiotics and reminded her to give todays doses, which she replied "okay".'*

The panel took into account that you maintained throughout your oral evidence at this hearing that you had correctly recorded your omissions on 5 April 2019.

The panel determined that there is cogent evidence to draw the inference that in response to your error on 5 April 2019 being brought to your attention, you made the retrospective entries of your omissions in an attempt to conceal overlooking Resident A's medication requirements.

The panel concluded that, by the standards of ordinary and decent people, your actions were dishonest in attempting to create the false impression that you recorded your omissions on 5 April 2019 when you had not.

Accordingly, the panel finds charge 3 proved.

**Fitness to practise**

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether 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**

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

In her submissions, Ms Hare referred to the case of *Council for the Regulation of Health Care Professionals v (1) GMC (2) Biswas* [2006] EWHC 464 (Admins) and *Roylance v General Medical Council.*

Ms Hare invited the panel to take the view that the facts found proved amount to misconduct. She referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code). She identified the specific, relevant standards where, she submitted, your actions amounted to misconduct.

Ms Hare submitted that the charges found proved represent significant departures from the acceptable standards of a registered nurse. She submitted that Resident A, who had a chest infection, was not given her prescribed antibiotics on two occasions. Further, she submitted that you dishonestly attempted to disguise the reasons why you had not done so by retrospectively marking that Resident A was having difficulty swallowing. She submitted that in order to attempt to legitimise your error, you amended another registered nurse's record, thus acting for your own gain. She submitted that you acted contrary to the best interests of Resident A by leaving her without the care she required and was entitled to, and incorrectly recording the state of her ability to swallow.

You submitted that you did not act dishonestly and maintain the view that you did the right thing by recording your failure to administer the medication to the resident at the time.

**Submissions on impairment**

Ms Hare moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Hare invited the panel to find your fitness to practise impaired on both public protection and public interest grounds.

Ms Hare submitted that your actions put Resident A at unwarranted risk of harm. She stated that by failing to administer the antibiotics to Resident A as prescribed, you failed to provide Resident A with the care she required (and was entitled to) and consequently put her at risk of her chest infection getting worse (as left untreated) and/or her chest infection not recovering as quickly as it could have done. She submitted that by making retrospective entries in Resident A's MAR chart and amending the entry that was recorded by Colleague B, you created a false record of the treatment Resident A had received and needs, thus putting her at risk of incorrect treatment going forward.

In addition, Ms Hare submitted that, failing to administer medication and not keeping clear and accurate records presents an obvious risk to patients that they will not be being cared for and/or they are at risk of receiving inappropriate care. She stated that it is this wider risk associated with the failures, rather than the immediate consequences to Resident A, that is relevant.

Ms Hare submitted that failing to administer medication, failing to keep accurate and clear records, and then amending records in order to create a false impression for your own gain, is contrary to the fundamental duties of a registered nurse and brings the profession into disrepute. She submitted that public confidence in the profession would be undermined if impairment was not found in the case. She further submitted that effective care and acting with honesty and integrity are at the heart of the profession and your actions in the charges found proved breached fundamental tenets of the profession.

Ms Hare submitted that all actions of dishonesty are serious regardless of whether it leads to direct patient harm. She stated that it is essential that registered nurses act with honesty and integrity, as well as in accordance with the duty of candour, in order to ensure that any mistakes made are appropriately acted upon in order to minimise the impact of them to protect the public. She submitted that, consequently a dishonest nurse, who is more likely to be tempted to 'cover things up' rather than acting upon them is a risk to the public.

Further, Ms Hare submitted that you have not demonstrated sufficient remorse, insight or reflection upon the harm caused to the profession. She stated that you have not yet acknowledged your dishonesty. She submitted that, until you acknowledge the mistakes that were made and reflect on why they happened so that you can ensure steps are in place to prevent you from doing so again, you are liable to repeat the behaviour of the kind found proved in the future. In terms of remediation, she submitted that you have not provided any employer/colleague references or evidence of training to demonstrate the standard of your practice since the incident. She submitted that, crucially, given the concerns are attitudinal in nature they are thus inherently difficult to remedy and are not simply remedied by continuing practice.

You stated that you qualified as a nurse in 2008. You submitted that prior to the referral made to the NMC, you have never been involved in any regulatory concerns. You submitted that you have worked in many places throughout your career and there have never been any issues.

You explained that since you left the Home, you have not stopped working as a nurse as you believed that you were right. You informed the panel that since the incident you have worked as a nurse on a one to one basis with patients and colleagues, which required a high degree of honesty.

You also informed the panel that you later worked with NHS Test and Trace. You stated that in this role you were working from home alone and unsupervised, which showed that you were honest. You submitted that you have managed to help the public in your role with NHS Test and Trace, following protocols and reporting to team leaders.

You submitted that you have completed training, in relation to health and safety. You stated that you are willing to do further training in order to work with the public again, such as training on medication either with colleagues or with companies. You stated that you are still looking to improve and understand the importance of updating knowledge in nursing.

You went on to tell the panel that you still felt deprived by the outcome, that you did what you did and dishonesty was the last thing on your mind. You said that you do things as you go, you write down medication as you go and you know as a nurse you have responsibilities and that you never fail to deliver. You told the panel that you did not do any harm to the patient.

You told the panel that you have suffered because of this case. Prospective employers want to know why your PIN has no expiry date and therefore you have to explain about this case. You stated that this makes it difficult for you to obtain employment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

**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:

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

*To achieve this, you must:*

*1.2 make sure you deliver the fundamentals of care effectively*

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

***8 Work co-operatively***

*To achieve this, you must:*

*8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

*8.5 work with colleagues to preserve the safety of those receiving care*

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

*To achieve this, you must:*

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

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

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

*10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.*

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

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

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

*14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***

*To achieve this, you must:*

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

***20 Uphold the reputation of your profession at all times.***

*To achieve this, you must:*

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

*20.2 act with honesty and integrity at all times […].'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your actions, particularly dishonesty, did fall far below of the conduct and standards expected of a nurse and amounted to misconduct.

The panel determined that you failed to administer antibiotics on two occasions to Resident A then deliberately sought to minimise your actions by falsely claiming that this was a result of Resident A not being able to swallow the antibiotics, rather than acknowledging your error. The panel determined that some effort had gone into the continued dishonesty as you retrospectively marked that Resident A was having difficulty swallowing and amended another registered nurse's record to conceal your error.
The panel was of the view that the dishonesty related directly to your clinical practice for your own gain, rather than the best interests of Resident A.

The panel were concerned that your continuing denial of your dishonesty was evidence of attitudinal issues.

The panel determined that the facts found proved do amount 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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

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

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

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

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

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered this test and determined that all four limbs were engaged in this case. The panel found that Resident A was put at unwarranted risk of harm as a result of your misconduct. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty serious.

The panel next went on to consider the matter of insight. The panel considered your explanation of events. The panel took into account that you have admitted to not administering Resident A's antibiotic medication, however, you have failed to acknowledged your dishonesty by attempting to conceal that omission by retrospectively altering the MAR chart, by amending another registered nurses record and by falsely claiming that the reason you failed to administer the medication was because Resident A was unable to swallow the capsules. Further the panel was concerned that you actively tried to blame colleagues. This was evident in your cross examination of them on the basis that they were lying. You inferred that they were aggrieved due to your better knowledge of how Resident A should have her medication administered.

The panel determined that, while you do acknowledge that you should have escalated your failure to administer Resident A's antibiotics at the time, you have provided no cogent reason for your omission on either occasions, at a time when you would have had an opportunity to contact a General Practitioner (GP) and resolve the issue. Rather, you told the panel that you thought it was acceptable to simply write in the notes and leave it to the night nurse to deal with.

The panel was of the view that you have demonstrated little or no understanding of how your actions put a patient at risk of harm and how this impacted negatively on the reputation of the nursing profession nor have you explained how you would handle similar situations differently in the future. The panel is also of the view that you have shown little evidence of remorse.

The panel was satisfied that the misconduct in this case is attitudinal and therefore inherently difficult to remediate. Further, the panel has seen no evidence of any efforts you have made to address the specific concerns raised about your practice.

The panel is of the view that due to the lack of insight, remorse or any evidence of remediation, there remains a real risk of repetition of the concerns raised. The panel determined that there was insufficient evidence to allay its concerns that you may currently pose a risk to patient safety. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case where a nurse had acted dishonestly and

put a patient at risk of harm for personal gain. The panel determined that 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 12 months with a review. 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, which included reference to a number of relevant judgments.

**Submissions on sanction**

Ms Hare informed the panel that in the Notice of Hearing, dated 27 January 2022, the NMC had advised you that it would seek the imposition of a six month suspension order with review if it found your fitness to practise currently impaired.

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

- Conduct which put patients at risk of suffering harm (failings to administer medication and keep accurate records…)
- Continuing act (5 to 6 April 2019, with some time ‘off shift’ in between).
- Dishonest attempt to cover up failings

- Lack of insight into failings, as well as seeking to blame other registered nurses for your failings
- Lack of insight into failings (denial (and continuing denial) of Charges 2 and 3 as well as seeking to blame other registered nurses for your failings and limited evidence of reflection on the risks to the public and the profession that flow from the failings (whether you accept them or not)).

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

- Single episode of misconduct
- Degree of insight (early admission of charge 1).

Ms Hare invited the panel to consider a six month suspension order with a review before expiry.

Ms Hare submitted that a caution order is not appropriate as it would not reflect the seriousness of the case. She submitted that a caution order does not affect your right to practice and given the panel have found that your fitness to practise indicated a risk to patient safety, it is submitted that a caution order would not be enough to protect the public, given it will allow you to continue to practise without any restriction.

Ms Hare further submitted a conditions of practice order would not sufficiently address the concerns about public confidence or proper professional standards and conduct. She submitted that cases involving dishonesty are particularly serious and you have breached your duty of candour to be open and honest. She submitted that there are no conditions that could be put in place to ‘mark’ those concerns. Further, she submitted that your dishonesty means conditions of practice are unlikely to be appropriate/workable given the nature of those concerns.

Ms Hare submitted that it is open to the panel to impose a suspension order of up to one year. She submitted that this would prevent you practising as a registered nurse during the

period the order is in force. She submitted that a six month suspension order with a review before expiry would mark the seriousness of your behaviour and thus declare and uphold the standards of the profession, protecting the public's trust and confidence in the profession. She submitted that it would also give you an opportunity to demonstrate insight/progress with the possibility of restrictions on your practice being lifted if you can demonstrate that the concerns have been sufficiently addressed, whilst protecting the public/public confidence in the interim by preventing you from practising.

Ms Hare submitted that a striking-off order is likely to be appropriate when what the registrant has done is fundamentally incompatible with being a registered professional. She submitted that given it is a single episode of misconduct (albeit over two days), the panel may consider that a striking-off order is disproportionate at this stage.

You submitted that having worked unsupervised, you understand the role of a nurse.

You explained that you have worked in various Care Homes and you have managed to work with the public. You stated that this included various responsibilities, such as updating care plans and amending documents in an honest way.

You submitted that you are very much capable of attending to the public without any binding restrictions.

You submitted that you have undertaken further training in safeguarding. You explained that you understand that when dealing with people it is not up to you decide what needs to be done. You clarified that what you mean by this is that you should have escalated the matter. You stated that, had you escalated the matter at the time you would not be here now.

You submitted that this has been a learning curve for you and that you regret not seeking help at the time. You also stated that you have been truthful from the start.

You told the panel that you have been a nurse since 2008 and you have had no problems before this.

You stated that you do not want to lose your job as you have worked so hard on it. You explained that you have suffered since the NMC referral and have had to take six months out of work due to this matter.

You submitted that you wished this had never happened and you would never do anything to put anyone at harm. You stated that if you put any patient at risk it was not your intention to do so.

You stated that you are willing to take further courses if necessary, and explained that nursing is an ongoing practice with many changes.

You submitted that you have been truthful from the start, that you have learned from this and that it will never happen again.

You submitted that you would like to provide three references. However, you later clarified that you had not yet contacted your selected referees for references as you were not aware that their reference would be required. You listed the following referees:

- NHS Professional Bank;
- Sunny Care Agency, an agency you worked with after the incident; and
- An RGN colleague who has worked closely with you.

You were later able to obtain one reference, which you presented to the panel in the form of a WhatsApp message, which stated:

> *'To whom it may concern,*
> *I have known Elita Matri Sibanda (RGN) for over 7 years as a work colleagues. She is loving and caring person. She is honest and always willing to help at the*

*Nursing Home, she would put in extra hours to assist others staff. She is kind hearted and shows love and respect towards others. Thank you very much '*

This reference was from a colleague who you told the panel had worked closely with you for seven years.

Ms Hare, submitted that she made some general observations from the reference put before the panel. She acknowledged that you felt the reference was relevant and important and stated that the NMC is not in dispute that you would have worked with other people given that you have been working as nurse. She submitted that the reference has a name there but it is not signed, there is no identification to back it up, it does not have a declaration of truth and it is not known if the referee is aware of how the reference will be used. She submitted that the panel should place little weight on the reference.

**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:

- Conduct which put patients at risk of suffering harm by failing to administer medication and keep accurate records
- Actions which occurred over more than one day (5 to 6 April 2019)
- Dishonest attempt to cover up your failings
- Lack of insight into your failings, as well as seeking to blame other registered nurses

- Limited evidence of reflection on the risks to the public and the profession that flow from the failings (whether you accept them or not)
- Continued denial of charge 2 and 3, which was maintained to the conclusion of the hearing.

The panel also took into account the following mitigating features:

- Single episode of misconduct, involving one resident.

The panel acknowledged the reference provided, however, it determined to give little weight to this reference for the reasons outlined in Ms Hare's submissions.

The panel noted Ms Hare's submissions that the panel should consider as a mitigating factor that you have shown a degree of insight in your early admission to charge 1. However, the panel remained concerned that your reasoning and subsequent behaviour regarding this admission is what was found to be dishonest. It therefore determined that this was not a mitigating feature in the circumstances of this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would not protect the public or satisfy public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate

nor in the public interest to impose a caution order as it would not provide sufficient protection to the public.

The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, and noted that your dishonesty presented evidence of attitudinal problems. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the dishonesty in this case. The misconduct identified in this case was not something that can be addressed through retraining.

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 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.

The panel went on to seriously consider whether a striking-off order would be appropriate but in the circumstances decided that it would be disproportionate at this time.

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

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

The panel considered that this order is necessary 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 determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct. Further, the panel determined that this would give you the opportunity to recognise the level of dishonesty that has been found proved by the panel and to address the gravity of these issues. The panel recognised that this may take some time and therefore concluded that 12 months was more appropriate than the six months proposed by the NMC.

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:

- A reflective piece which addresses the fact that your actions have been found to be dishonest and the implications of that dishonesty for patients, colleagues, the public and the profession;
- References and testimonials from any employers or voluntary organisations;
- Training which addresses the specific issues in this case including duty of candour and dishonesty.

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 interest until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

**Submissions on interim order**

The panel took account of the submissions made by Ms Hare. She submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and it is otherwise in the public interest.

Ms Hare invited the panel to impose an interim suspension order for a period of 18 months. She submitted that not to impose one would be inconsistent with the substantive decision the panel has already made.

You made no submissions.

**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, for the reasons already identified in the panel's determination

for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow for any possible appeal period.

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

That concludes this determination.