Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting

Wednesday 19 July 2023

Virtual Hearing

Name of Registrant:	Natasha Maria Chipindiko
NMC PIN	18A0015E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – January 2018
Relevant Location:	Wolverhampton
Type of case:	Lack of competence
Panel members:	Debbie Hill (Chair, Lay member) Des McMorrow (Registrant member) John Penhale (Lay member)
Legal Assessor:	Alain Gogarty
Hearings Coordinator:	Monsur Ali
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7 and 8
Fitness to practise:	Impaired
Sanction:	Conditions of practice order (24 months with a review)
Interim order:	Interim conditions of practice order (18 months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mrs Chipindiko's registered email address by secure email on 7 June 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and the fact that this meeting was heard virtually.

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

Details of charges

'That you a registered nurse, between 8 December 2019 and the 28 October 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise as a Band 5 nurse in that:

1. On 9 December 2019 incorrectly administered 35 units of Novorapid to Resident A instead of the prescribed dosage of 6 units.

2. On 25 June 2020 failed to administer a 100mg Gabapentin tablet to Patient A, the prescribed dosage being two 100mg tablets.

3. On 25 June 2020 incorrectly documented on Patient A's MAR chart that you had administered two 100mg Gabapentin to them.

4. On or before 20 July 2020:

(a) Left the medication trolley unattended with the keys in the lock.

(b) Administered Digoxin to a patient before checking their pulse.

(c) Administered all the patient's medication in one go, via PEG, rather than individually with a water flush in between.

(d) Failed to correctly administer Fortisip to a patient.

(e) Failed to complete a patient's resident of the day form.

(f) Needed reminding to complete wound charts and care plans after dressings had been changed.

(g) Failed to check a patient's care plan before applying a dressing.

(h) Failed to adequately complete a care plan for a patient who suffered a skin tear.

5. On 31 July 2020 incorrectly administered 60mg of Isosorbide Mononitrate to Patient B instead of the prescribed dosage of 30mg.

6. On 31 July 2020 incorrectly documented on Patient B's MAR chart that you had administered 30mg of Isosorbide Mononitrate to them.

7. On 1 August 2020 increased Patient C's oxygen levels before:

(a) Seeking the advice from a senior nurse and/or

(b) Seeking the advice of a GP.

8. Between the 23 April 2021 and 27 October 2021 failed to:

(a) Document drugs that had been administered to patients on 24 September 2021.

(b) Document drugs that had been administered to patients on 30 September 2021

(c) Document drugs that had been administered to a patient on 27 October 2021.

(d) Document patient observations in a timely manner on 23 April 2021.

(e) Communicate handovers effectively on 23 April 2021 and/or 22 June 2021.

And in light of the above your fitness to practise is impaired by reason of your lack of competence.'

Consensual Panel Determination

At the outset of this meeting, the panel was made aware that a provisional agreement of a Consensual Panel Determination (CPD) had been reached with regard to this case between the Nursing and Midwifery Council (NMC) and Mrs Chipindiko.

The agreement, which was put before the panel, sets out Mrs Chipindiko's full admissions to the facts alleged in the charges, that her actions amounted to lack of competence, and that her fitness to practise is currently impaired by reason of that lack of competence. It is further stated in the agreement that an appropriate sanction in this case would be a Conditions of Practice Order for a period of 2-years with a review.

The panel has considered the provisional CPD agreement reached by the parties.

That provisional CPD agreement reads as follows:

'The Nursing & Midwifery Council ("the NMC") and Natasha Maria Chipindiko ('Ms Chipindiko'), PIN 18A001E ("the Parties") agree as follows:

1. Ms Chipindiko is content for her case to be dealt with by way of a CPD meeting. Ms Chipindiko understands that if the panel determines that a more severe sanction should be imposed, the panel will adjourn the matter for this provisional agreement to be considered at a CPD hearing.

2. Ms Chipindiko understands that if the panel proposes to impose a greater sanction or make other amendments to the provisional agreement that are not agreed by Ms Chipindiko, the panel will refer the matter to a substantive hearing.'

The charges

3. Ms Chipindiko admits the following charges:

That you a registered nurse between 8 December 2019 and the 28 October 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise as a band 5 nurse in that:

1. On 9 December 2019 incorrectly administered 35 units of Novorapid to Resident A instead of the prescribed dosage of 6 units.

2. On 25 June 2020 failed to administer a 100mg Gabapentin tablet to Patient A, the
prescribed dosage being two 100mg tablets.

3. On 25 June 2020 incorrectly documented on Patient A's MAR chart that you had administered two 100mg Gabapentin to them.

4. On or before 20 July 2020:
(a) Left the medication trolley unattended with the keys in the lock.
(b) Administered Digoxin to a patient before checking their pulse.
(c) Administered all the patient's medication in one go, via PEG, rather than individually with a water flush in between.
(d) Failed to correctly administer Fortisip to a patient.
(e) Failed to complete a patient's resident of the day form.
(f) Needed reminding to complete wound charts and care plans after dressings had been changed.

(g) Failed to check a patient's care plan before applying a dressing.
(h) Failed to adequately complete a care plan for a patient who suffered a skin tear.

5. On 31 July 2020 incorrectly administered 60mg of Isosorbide Mononitrate to Patient B instead of the prescribed dosage of 30mg.

6. On 31 July 2020 incorrectly documented on Patient B's MAR chart that you had administered 30mg of Isosorbide Mononitrate to them.

7. On 1 August 2020 increased Patient C's oxygen levels before:
(a) Seeking the advice from a senior nurse and/or
(b) Seeking the advice of a GP.

8. Between the 23 April 2021 and 27 October 2021 failed to;
(a) Document drugs that had been administered to patients on 24 September 2021.
(b) Document drugs that had been administered to patients on 30 September 2021
(c) Document drugs that had been administered to a patient on 27 October 2021
(d) Document patient observations in a timely manner on 23 April 2021.
(e) Communicate handovers effectively on 23 April 2021 and/or 22 June 2021.

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

The facts

4. Ms Chipindiko appears on the register of nurses, midwives and nursing associates maintained by the NMC as a Registered Nurse, and has been on the NMC register since 12 January 2018.

5. This case relates to two separate referrals. The first referral was made on 10 December 2019 by Sherise Osbourne ('SO') a Clinical Lead for Select Healthcare, which related to an incident that occurred at the Royal Park Care Home ('Home 1') on 9 December 2019. At the time of the referral Ms Chipindiko was employed as nurse at Home 1, initially starting as a Bank Nurse in August 2019 and then becoming a permanent member of staff on 2 December 2019.

6. On 9 December 2019 Ms Chipindiko administered 35 units of insulin to Resident A (charge 1). Resident A was a Type 1 diabetic, and according to the Medication Administration Record chart ('MAR') was prescribed daily, 6 units of Novorapid insulin in the morning and at lunchtime, and 4 units of Novorapid insulin in the evening, to be administered via an insulin pen. In addition, Resident A was prescribed 15 units of Tresiba Flextouch (Degludec insulin) at night-time via subcutaneous injection.

7. On the morning of the 7 and 8 December 2019, Ms Chipindiko administered 6 units of Novorapid insulin to Resident A as prescribed. On 9 December at 06.11, Ms Chipindiko administered 35 units of Novorapid insulin to Resident A, despite the MAR chart indicating that 6 units was to be administered. Ms Chipindiko recorded on Resident A's Insulin Administration Record that she had administered 35 units of Novorapid to Resident A on 9 December 2019 at 06.11, including that the insulin pen had 'finished'.

8. Ms Chipindiko handed over to SO that morning that Resident A had no more Novorapid insulin in stock. In light of this information, SO decided to check Resident A's insulin stock and when looking at the chart noticed that he had been administered 35 units of insulin rather than the prescribed 6 units. SO alerted the Team Leader, Symone Salmon ('SS') about her concerns.

9. SS and another carer subsequently went and checked Resident A at around 08.50. Resident A was observed to be 'very sweaty/clammy' and aside from opening his eyes once, was unresponsive to SS and the carer when speaking to him. An ambulance was called and during that telephone call, Resident A was having mini seizures, was jerking and unresponsive to a pinch or when calling his name. Resident A was taken to hospital and made a full recovery.

10. Ms Chipindiko provided a local statement on 9 December 2019 apologising and admitting that she had made a mistake when she had incorrectly administered the wrong amount of insulin to Resident A. In addition, Home 1 conducted a meeting with Ms Chipindiko on 9 December 2019. In that meeting Ms Chipindiko stated, 'I thought that he [Resident A] was prescribed 64 units but I only could give 35 units because the pen ran out'. Ms Chipindiko also stated that she didn't know why she had done it and stated that she was 'sorry.'

11. Ms Chipindiko's employment at Home 1 was subsequently terminated on 10 December 2019 under her probation period.

12.The NMC received the following relevant documents from Home 1 when undertaking its own investigation into this concern:

- *Incident Report Form*
- *Resident A's Insulin Administration Record*
- *Resident A's MAR chart*
- *Local Statement from SO dated 9 December 2019*
- *Local Statement from SS dated 9 December 2019*
- *Local Statement from the carer, TC undated*
- *Ms Chipindiko's Local Statement dated 9 December 2019*
- *Minutes of Meeting held with Ms Chipindiko dated 9 December 2019*

13. Ms Chipindiko admitted Charge 1 in its entirety on 26 November 2022 via her Case Management Form. Moreover, the NMC was provided with a reflective

statement from Ms Chipindiko on 25 February 2020. In that statement Ms Chipindiko accepted that she had administered the wrong dose of insulin to Resident A (as set out in the charge).

14. The second referral was received on 11 August 2020 from Buddy Bondo ('BB') a Care Home Manager with the Priory Group, and related to incidents that occurred at Bentley Court Care Home ('Home 2'). At the time of the referral Ms Chipindiko was employed as a nurse at Home 2, commencing her employment at Home 2 on 8 April 2020.

15. On 25 June 2020 Ms Chipindiko failed to administer the correct dosage of Gabapentin to Patient A (charge 2). According to Patient A's MAR chart they were to be prescribed a dosage of two 100mg Gabapentin tablets at night. However Ms Chipindiko only administered one 100mg tablet to Patient A. This error was discovered on 26 June 2020 when a routine count of medication was undertaken. When the Medication Management Checklist was looked at, it showed that there was one extra tablet of Gabapentin in stock.

16. Subsequently, Patient A's MAR chart was checked and it was discovered that Ms Chipindiko had incorrectly documented in Patient A's MAR chart that on the evening of 25 June 2020 that she had administered two 100mg tablets of Gabapentin (charge 3).

17. On or before 20 July 2020 Ms Chipindiko completed three day shifts with Sarah Turner ('ST') the Clinical Lead Nurse for Home 2 (charge 4). During those shifts ST observed Ms Chipindiko doing the following:
a. Leaving the medication trolley outside room 43 unattended with the keys still in the trolley (charge 4a), whilst administering medication to a patient in room 37.
b. Administering Digoxin to a patient without first checking the patient's pulse (charge 4b).

c. Crushing all of a patients medication into one medication pot then administering it them all to the patient via the PEG tube in one go. Ms Chipindiko should have administered the medication to the patient individually via the PEG tube and should have conducted a water flush in between each administration (charge 4c).
d. The patient in room 43 had is medications administered via his PEG tube. ST was concerned that Ms Chipindiko was unable to administer the medications via this route because the patient became distressed during the process. This resulted in the patient's stomach contents curdling the Fortisip that was in the syringe causing the contents spilling out onto the patient (charge 4d).
e. ST explained to Ms Chipindiko the process of completing Resident of the Day forms for patients. Ms Chipindiko managed to complete room 55 evaluations but ST had concerns with Ms Chipindiko's time management and because Ms Chipindiko did not manage to complete the form, ST completed it on her behalf (charge 4e).
f. ST observed that although Ms Chipindiko was completing the wound charts and care plans after dressings had been changed, Ms Chipindiko needed reminding to complete them despite previous explanations provided to her (charge 4f).
g. ST observed that on one occasion, when a patient required their dressing changed, that she had to remind Ms Chipindiko to check the care plan in order to determine which dressing was to be applied to the patient (charge 4g).
h. A patient had suffered a skin tear on shift, and ST asked Ms Chipindiko to devise a care plan for the patient. However, ST observed that the care plan devised by Ms Chipindiko was not completed properly and was not up to the standard expect. ST explained to Ms Chipindiko that the care plan required further information and although Ms Chipindiko completed the care plan again it was still not detailed enough. Ms Chipindiko was again requested to rewrite the care plan (charge 4h).

18. ST observed over the three day shift with Ms Chipindiko's that her management of medications had improved. That Ms Chipindiko was thorough in her checking, counting and completion of MAR charts, with the exception of the first medication round whereby Ms Chipindiko required advice and assistance on the processes involved. However ST did observe that Ms Chipindiko required further support with

documentation, such as writing care plans, understanding and completing Home 2's documentation. ST noted that Ms Chipindiko did not 'come across as being confident in her work and required additional support and additional time to learn tasks.' ST recommended that Ms Chipindiko to work alongside day nurses one day a week for guidance and support due to a care home setting being 'quite challenging.'

19. On 31 July 2020 Ms Chipindiko incorrectly administered medication to Patient B (charge 5). Patient B was prescribed 60mg tablet of Isosorbide Mononitrate daily, but only half of the tablet, 30mg was to be administered to Patient B daily in the morning. Ms Chipindiko instead administered the full tablet to Patient B, double the dosage prescribed. The incident was discovered when another nurse checked Patient B's MAR chart and noticed that Ms Chipindiko had documented that 60mg of Isosorbide Mononitrate had been administered to Patient B on 31 July 2020 (charge 6). The GP was notified of the incident and the advice provided was that Patient B's blood 6 Page 6 of 27 pressure was to be monitored every 2-hours. There is no evidence that Patient B suffered any harm as a result of receiving double the dosage prescribed. Ms Chipindiko provided a local statement on 3 August 2020 accepting her error stating that she did not 'check the prescription properly'.

20. On 1 August 2020 Ms Chipindiko increased Patient C's oxygen levels before seeking advice from a senior nurse and/or a GP (charge 7). Patient C was independent with taking their medication, but was on oxygen whereby she had to be monitored regarding their oxygen saturations. Patient C had to be checked at least once per shift which included checking their tubing to ensure that there were no kinks and the machine was turned on at all times.

21.On 1 August Ms Chipindiko informed ST that she had turned Patient C's oxygen up to 3 litres from 2 litres, because her saturation levels were low at around 53%. ST informed Ms Chipindiko that the oxygen levels should not be increased because

it was classified as a prescribed medication, and that if the oxygen levels were to be increased advice should be sought beforehand from a GP (charge 7b).

22.Ms Chipindiko provided a local statement dated 3 August 2020 in which she accepted that when she checked Patient C's saturation levels they were at around 53% and decided to increase the oxygen levels, because she 'thought it would help'. Ms Chipindiko stated that having increased the oxygen levels her saturation levels were not increasing decided to call the paramedics. The paramedics arrived and managed to stabilise the saturation levels.

23.Ms Chipindiko attended a probationary review meeting on 4 August 2020 headed by BB. In that meeting Ms Chipindiko stated that when she attended Patient C she found that Patient C was unresponsive and 'appeared with drowsy eyes.' She checked her vital signs and noticed that the saturation levels were around 52%. She assisted Patient C to sit up and looked at the nasal tube, which was upside down and so readjusted it. She then checked the saturation levels again after 20 minutes but they were not increasing. Ms Chipindiko stated that she made a decision to increase the oxygen level from 2 to 3 litres, then pressed the emergency buzzer for assistance. Another nurse arrived and Ms Chipindiko explained what had happened, then called for an ambulance. Ms Chipindiko accepted that she did not call for advice prior to increasing the oxygen levels, stating that she 'didn't know what to do' and 'panicked.'

24.Ms Chipindiko during the meeting accepted that she was aware of the NMC Code recognising that she should work within the limits of her competency. Ms Chipindiko further accepted that should have sought assistance from a suitably qualified and experienced professional to undertake any action or procedure that was beyond the limits of her competency (charge 7a). Ms Chipindiko accepted that her actions regarding the increase of Patient C's oxygen was not within her limitations, citing again that she 'panicked' because Patient C's saturation levels were low.

25.Ms Chipindiko's employment with Home 2 was terminated on 4 August 2020 under her probation period. 26.The NMC, as part of its own investigation, obtained the following relevant documents from Home 2:

• Witness statement and associated exhibits from ST, Clinical Lead Nurse, dated 19 October 2021

• Emails from ST to BB dated 20 July 2020

• Local Statement from ST dated 3 August 2020

• Minutes of a meeting with Ms Chipindiko dated 4 August 2020

• Local Statement from EB dated 3 August 2020

• Local Statement from Ms Chipindiko dated 3 August 2020

• Incident Investigation Form (Datix) dated 4 August 2020

• Medication Incident Report dated 31 July 2020

• Datix Report undated relating to the incident with Patient B

• Further local statement from Ms Chipindiko dated 3 August 2020

• Medicines Management Checklist •

Patient A's MAR chart • Patient A's Care Plan and Pre-admission Assessment

• Trained Staff or Carers Medication Notes Form 27.

Ms Chipindiko admitted Charges 2, 3, 4, 5, 6 and 7 in their entirety on 26 November 2022 via her Case Management Form. Moreover, the NMC were provided with a reflective statements from Ms Chipindiko on 2 September 2020 whereby Ms Chipindiko accepted:

a. That she had not prescribed Patient A the correct dosage of Gabapentin.

b. That she had administered double the dosage of Isosorbide Mononitrate to Patient B.

c. That she acted outside her level competency by increasing Patient C's oxygen levels without seeking advice beforehand.

28.On 1 March 2021 Ms Chipindiko commenced employment with Walsall Healthcare NHS Trust (the 'Trust') as a Staff Nurse. Ms Chipindiko was, at the time

of her employment with the Trust, the subject of an Interim Conditions of Practice Order that was imposed on 2 September 2020 for a period of 18 months. One of the conditions of that order was that a Personal Development Plan ('PDP') must be created with her Supervisor to assist with Ms Chipindiko's development.

29.The Matron for the Acute Care Ward tasked Karine Brown ('KB') to help Ms Chipindiko with her PDP. KB states that Ms Chipindiko is competency assessed for oral medication every month together with being supervised during drug rounds. KB states that when she or other nurses worked with Ms Chipindiko it was noticed that the drug rounds were not completed in a systematic way. Ms Chipindiko would administer medication to a patient but would then sign for the drugs administered away from the patient, or would become distracted and not sign for the drugs, having to be reminded to sign for the drugs that had been administered to patients. As part of Ms Chipindiko's PDP KB would discuss with her ways of developing and improving Ms Chipindiko's clinical practise in order that drugs rounds are completed in a safe and timely manner.

30. It was observed that Ms Chipindiko 'lacked confidence' and the nurses and the Personal Development Nurse ('PDN') worked with Ms Chipindiko to offer support, ensuring that Ms Chipindiko completed all safety checks prior to the administration of medication. Such support was in the form of; placing a small dot in the box on the drug chart to ensure that all drugs had been dispensed, ensure that Ms Chipindiko stayed with the patient until the drugs had been taken, ensuring that the drug charts had been completed before moving onto the next patient. Additionally, Ms Chipindiko's patients' drugs charts were also audited by the Nurse in Charge, the Ward Manager or the PDN several times per shift ensuring that all medication had been given. In particular the following observations were made (charge 8) between 23 April 2021 and 27 October 2021, as set out in the PDP: Ms Chipindiko failed to:

a. Document drugs that had been administered to patients on 24 and 30 September 2021. b. Document drugs that had been administered to a patient on 27 October 2021

c. Document patient observations in a timely manner on 23 April 2021.

d. Communicate handovers effectively on 23 April 2021 and/or 22 June 2021.

31. Ms Chipindiko was requested to complete a reflective piece on how she could improve her drug rounds. KB discussed the reflective piece with Ms Chipindiko and it was recognised by Ms Chipindiko that she was being distracted when completing drug charts, and how the measures that were put in place would ensure that drug rounds were completed safely and efficiently.

32. KB states that the charge nurses felt that the registrant seemed to be trying too hard or over thinking matters, which may have been contributing to her errors. KB further states that the Ward Manager recognised that the registrant did not come from an acute care background and would require ongoing clinical and educational support. This also included support regarding deteriorating patients, communication and timely observations because it was found that Ms Chipindiko was not documenting enough information in the medical notes, which was the same for patient handovers where important information was missing.

33.KB states that the PDN, Ward Manager and Nurse in Charge worked with Ms Chipindiko, observing her practice and offering regular feedback. During a shift Ms Chipindiko was provided time to reflect on the care delivered, and was able to discuss and document a clear and concise summary of the care delivered. Ms Chipindiko's observations were monitored and it was noted that Ms Chipindiko was able complete her observations on time by prioritising her time, recognising that a patient was deteriorating and escalating appropriately.

34. KB states that Ms Chipindiko has attended the Acute Illness Management study day which had a positive impact on her care delivery and communication skills. KB further states that there has also been positive improvement in the care that Ms Chipindiko provides to her patients and has also received positive feedback from Ms Chipindiko's work colleagues, patients and the educational support team.

35. Ms Chipindiko's remains employed by the Trust and remains subject to the interim order.

36. The NMC, as part of its own investigation, obtained the following relevant documents from the Trust:

- *Witness Statement from KB*
- *PDP plan, exhibited by KB*

37. Ms Chipindiko admitted charge 8 in its entirety via her legal representative on 7 March 2023.

Lack of Competence

38.The Parties agree that Ms Chipindiko's practise, as outlined in the charges, amounts to a lack of competence, as the failures identified represent an unacceptable low standard of professional performance that placed patients at a significant risk of harm.

39.To provide assistance to the Panel, the Court stated in the case of R(Calhaem) v. General Medical Council [2007] EWHC 2606 (Admin) that:
"The phrase "professional deficient performance" does not mean any instance of sub-standard work; it connotes a level of professional performance which indicates that the doctor's fitness to practise is impaired"

40.Moreover, the following may also be of assistance to the Panel, referring to the case of Holton v. General Medical Council [2006] EWHC 2960 (Admin):
"Deficiency is to be judged against the standard of his professional work that is reasonably to be expected of the practitioner….. His performance should be that which is to be expected of a competent practitioner in the circumstances"

41.At the relevant time, Ms Chipindiko was subject to the provisions of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"). The Parties agree that the following provisions of the Code were engaged in this case;

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

2 Listen to people and respond to their preferences and concerns
To achieve this, you must:
2.1 work in partnership with people to make sure you deliver care effectively

6 Always practise in line with the best available evidence
To achieve this, you must:
6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly
To achieve this, you must:
7.1 use terms that people in your care, colleagues and the public can understand

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event …..

10.3 complete records accurately …..

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) ……

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

42.At the material time Ms Chipindiko was working as a Band 5 nurse and although newlyqualified, having been admitted to the register on 12 January 2018, her level of competence fell short of the standards expected of a Band 5 nurse.

43.The concerns identified occurred whilst Ms Chipindiko was employed at three different establishments (whereby Ms Chipindiko remains employed at one of the establishments). The evidence clearly indicates that notwithstanding the support provided, Ms Chipindiko did not reach the competency and standards expected of a Band 5 nurse. In fact, a decision was made by two of Ms Chipindiko's employers to terminate her employment during her probationary period.

Impairment

44.The Parties agree that Ms Chipindiko's fitness to practise is currently impaired by reason of her lack of competence.

45.The general approach to what might lead to a finding of impairment was provided by Dame Janet Smith in her Fifth Report from Shipman, approved in the case of Council for Healthcare Regulation Excellence v. (1) Nursing and Midwifery Council and (2) Grant [2011] EWHC 927 (Admin) whereby Cox J stated at paragraph 76:

"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 professions 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 professions; and/or
d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future?

46.The parties agree that limbs a, b and c are engaged in this case.

Public Protection

47.In accordance with Article 3(4) of the Nursing and Midwifery Order 2001 ("the Order") the overarching objective of the NMC is the protection of the public. The Order states:"The pursuit by the Council of its overarching objective involves the pursuit of the following objectives
a) to protect, promote and maintain the health, safety and well-being of the public;
b) to promote and maintain public confidence in the professions regulated under this Order; and
c) to promote and maintain proper professional standards and conduct for members of those professions."

48.The case of Grant makes it clear that the public protection must be considered paramount and Cox J stated at para 71:

> *"It is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations … namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession."*

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

49.Ms Chipindiko's lack of competence had the potential to cause unwarranted harm to the patients that were in her care, and in the case of Resident A significant harm if it were not for others who recognised the danger and acted swiftly to prevent such harm from occurring. It was extremely fortunate that Resident A's insulin pen had 'run out' otherwise Ms Chipindiko would have administered 64 units of insulin to Resident A which could have had catastrophic consequences for Resident A. The evidence suggests that Resident A suffered harm due to Ms Chipindiko's lack of competence.

50.In relation to Patient C, although it could be said that Ms Chipindiko acted in good faith to prevent harm from occurring to Patient C, she accepted that her actions fell outside the area of her competence. By not seeking assistance from either a senior nurse or GP, and taking the actions that Ms Chipindiko did, could have resulted in serious harm being caused to Patient C. It was fortunate that Ms Chipindiko's actions did not cause such harm to Patient C.

51. Providing incorrect prescribed medication to patients and failing to check a patient's vitals prior to administering their medication, and not completing MAR charts correctly, and failing to document that medication has been administered to patients has the potential for patient harm. Patients are prescribed medication for a variety of reasons, such as; treating infection, pain relief, for preventative treatment, etc. Denying patients such medication and providing double the required dosage, and not checking vitals prior to administering medication, could have a detrimental effect on patients causing them harm.

52.Moreover, by incorrectly completing the necessary documentation, and failing to consider documentation before providing treatment to patients, could result in patient harm. Staff who subsequently look at the documentation may inadvertently

provide further medication to the patient or act in line with the treatment previously provided because the previous nurse did not follow the documentation specific to that patient's care. In this case Ms Chipindiko did not check a patient's care plan before making a decision to apply a wound dressing. Additionally, failing to communicate handovers effectively has the potential for patient harm because those receiving potential misinformation may inadvertently act on it when dealing with a particular patient.

53.Notwithstanding the support provided to Ms Chipindiko in her current employment, mistakes were still being made that had the potential of causing significant harm to those within her care (as set out in charge 8).

Public Interest

Has in the past brought and/or is liable in the future to bring the professions into disrepute

54.Registered professionals occupy a position of trust in society. The public, quite rightly, expect nurses to provide safe and effective care, and conduct themselves in ways that promotes trust and confidence in the profession and the NMC as its regulator. Ms Chipindiko's actions and omissions have the potential to cause patients and members of the public to be concerned about their safety and feel unnecessarily anxious about their healthcare treatment.

55.Notwithstanding the fact that Ms Chipindiko was a newly qualified nurse, she had a duty of care towards those who were under her care. This includes the presumption that Ms Chipindiko is sufficiently qualified and competent to read patients' prescriptions and MAR charts, to administer medication in line with those charts and/or prescriptions, to complete documentation to the standards required as a registered professional, and not to provide care outside the level of her competency.

56.The concerns identified could result in patients and members of the public being deterred from seeking medical assistance when they should. Not only has Ms Chipindiko's conduct brought the profession into disrepute, and that of the wider profession. In turn the conduct has the potential to undermine the public's confidence in the profession and the NMC as its regulator.
Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession.

57. The most fundamental tenet of the profession is that a registered professional has a duty to provide a high standard of care towards those receiving care. Ms Chipindiko breached this fundamental tenet by not providing the appropriate care to the standards required and expected of a Band 5 nurse. This duty also includes the following tenetsof the profession:
a. To prioritise people
b. To practice effectively
c. To preserve Safety.

58.Providing a high standard of care is fundamental to the nursing profession. Further the provisions of the Code, highlighted above, also constitute tenets of the nursing profession. By failing to provide a high standard of care at all times and complying with the core principles and specific paragraphs of the Code as set out above, the parties agree that Ms Chipindiko has breached fundamental tenets of the profession.

59.The panel may also find it useful to consider the comments of Cox J in Grant at paragraph 101:

"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the

Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."

Remediation, reflection, training, insight, remorse

60.With regard to future risk the Parties have considered the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) namely;
i. whether the concerns are easily remediable;
ii. whether they have in fact been remedied; and
iii. whether they are highly unlikely to be repeated.

61.The NMC guidance at FTP-13a indicates:

> *"that it can often be difficult, if not impossible, to put right the outcome of a clinical failing or behaviour, especially where it has resulted in harm to a patient. However rather than focusing on whether the outcome can be put right, decision makers should assess the conduct that led to the outcome, and consider whether the conduct itself, and the risks it could pose, can be addressed by taking steps, such as completing training courses or supervised practice."*

62.The concerns identified in this case are clinical in nature and as such can be remedied.

63. Ms Chipindiko made admissions at local level (which relate to charges 1, 2, 3, 5, 6 and 7 above), and admitted the regulatory concerns investigated by the NMC, which were; poor medications practice, acting outside the scope of your (Ms Chipindiko's) competence and medication errors. Moreover, as already stated Ms Chipindiko subsequently admitted to all the charges as set out above.

64.Ms Chipindiko provided reflective statements to the NMC.

65.In relation to Resident A, Ms Chipindiko stated:
"I misread the prescribed does as it looked like 64 units. I gave him what was left in the pen, which was 35 units and documented this partial administration of insulin on the medication chart. I also relayed this information during the hand over to the nurse (clinical lead)."

"I remember being apologetic in the letter to the service user for what he went through regarding my mistakes."

"The good thing that happened was the service user was eventually okay and survived his ordeal. Considering that it could have gone a lot worse as it can lead to harming his health e.g. seizures, palpitation and possibly death. Conversely, the patient had to experience this incident despite surviving the ordeal which could also have subsequently impacted him clinically. Despite this incident being totally a preventable incident, it also brought the healthcare service provider under disrepute and potential case of litigation from the service user's family and a clinical quality assurance investigation which could result in a loss of operational licence."

"This experience proves to essentially highlight areas of limited knowledge or an element of complacency on may part and it also further reflects a need to review clinical governance in the terms of medicines management and administration, i.e. insulin and controlled drugs at the home care."

"In conclusion, this experience has thoroughly increased by self-awareness of insulin management as it is an essential skill because it helps prevent the health problems that can occur when you have diabetes e.g. heart or kidney failure. To address my clinical limitation, I have done online training and I got certificates for introduction to insulin safety and the safe use of insulin (management and administration). I read the NICE and RCN guidelines to help me understand the situation, regarding the insulin management. This training covers the NMC code in part 6 of Safety of Nursing Practice stating that 'always practice in line with the

best available evidence'. It also covered part 13 of the code stating that 'recognise and work within the limits of your competence'."

I have learned to always double check my medications more than once before I give it to the service user. I will need to verify unusual doses especially in patients that I am not familiar with. Additionally, I will also not administer insulin prescribed in 'U' abbreviation instead of units as it should be written in full not abbreviation …."

"To help me in future if a similar situation arises, I will keep my knowledge and skills up to date by doing training to help boost my confidence."

66.In relation to Patient A Ms Chipindiko stated:

"It was a night shift when author mistakenly underdosed one of the medications for one of the service users. The service user was meant to receive two tablets at night of gabapentin as it was mentioned to their MAR chart, but the author mistakenly gave one tablet instead of two. On the drug chart it stated that the dose was written in mg and at the bottom of that it also stated that to give 2 doses at night. The authors mistake was that they only read the dose and did not read the dosage was written at the bottom. I did not realise this medication error until the next day."

"This whole situation made me feel greatly disappointed in myself, in allowing such an oversight to happen when I realised this the next day. This realisation also made me feel helpless, demoralised, since it is my duty of care to primarily safeguard my service users and promote their health. The fact that this had already happened made me hopeless and remorseful. Despite this incident not resulting in any significant harm to service sure A's health and well-being I am aware that would result in disappointment loss of confidence and trust of my clinical competency by both the clinical lead team, the patient and service user family. I was clearly embarrassed and upset by my actions."

"The good thing that happened was that it did not cause any significant harm to the service user but it could have led to a serious complication with the patient pain management and avoidable stress and distress. Another good thing that happened was upon the realisation that the day staff immediately escalated the situation and effectively followed the Doctors advise to monitor the patients' vitals and pain control, which I was able to do the same throughout the night. In order to maintain the patient health safety and well-being. Therefore, highlighting the entire multidisciplinary team (MDT) involved upheld their duty of care and candour effectively. I was also afforded a debrief meeting to investigated i.e. a route cause analysis of what had happen and why is to result in this drug administration error occurring. The tone of the meeting was not punitive, but rather supportive. The outcome of this brief outlined an action plan to help support me in my drug administration and management competency to eliminate incidents such as these in the future. Conversely, despite all the positive measures implemented, service user A (Patient A) was subjected to undue harm, stress or potential long-term effects this situation, which could have been avoided if I had done the right checks by effectively performing the standard operating procedure in my drug administration."

"From reflecting to the events that led to this incident it is some factors were clearly unavoidable. Such as tight time constraints due to limited staff resources. Therefore, resulting in disproportionate and unsafe patient to staff ratios. Also as highlighted the dosage on the MAR chart was illegible making it difficult to read the prescription clearly. It is more probable this could have led to misreading of the chart on my behalf. Hence why, National Patient Safety Agency (2010) argues, that poor prescriptions and limited resources results in ten times as much drug errors in comparison to human error or other factors. From doing this reflection it gave me the knowledge to stop and think what I did wrong and how I could have done it better to improve the care given to service users. It pointed out why I need to double check all the medications before I give them to the service user, to also

effectively reading the MAR chart and understanding written notes at the bottom. This afforded me to attain knowledge and awareness of the practice policy in addressing prescription discrepancies. By double checking I will be following the NMC standard for medicine management, which explains the 8 rights of administering medication e.g. right patient, right drug, right dose, right route, right time, right documentation, right reason and respond (NMC, (2019). This includes checking the name on the prescription chart, asking the service users name or date of birth and checking their room number or the name on their door. At the same time will check the label of the box if it is correct and in date. I will always use the BNF book to look for any medication I am not sure of and follow the home policy."

"In line with NMC code (2018) part 6 of Safety of Nursing Practice stating that "always practice in line with the best available evidence" I have taken the initiative to address my clinical limitation in drug and medication administration and management, I have done online training and I got certificates for introduction to drug management and administration. I have also read the NICE and Royal College of Nursing (RCN) guidelines to help me understand the situation. Effective consideration of the highlighted evidence facilitated my employer and myself to implement an appropriate action plan which included following a period of shadowed drug administration rounds for support and confidence building. Where I would be implementing my 8 rights as per clinical policy, (NMC, (2019) in drug administration. If the similar situation rises again, I would inform the clinical lead, fill the medication error paperwork and make sure the GP has been informed of the incident and follow his instructions."

67.In relation to Patient B Ms Chipindiko stated:

"In the morning service user X was given a whole tablet of isosorbide mononitrate instead of half a tablet. On the medication administration record (MAR) chart it stated the dose of the tablet and at the bottom it stated the dosage to be

administered i.e. the dose, or the amount drug to be administered attached to a time-frequency. The author only read the dose but did not read the small handwritten dosage that was at the bottom of the prescribed medication, which is where it stated to be given half. As soon as this drug administration error was highlighted, the medical staff was informed for advice, to establish a contingency plan to maintain patient safety. As advised by the on-call General practitioner (GP), the service X's blood pressure (BP) was monitored every 2 hours throughout the day. The service user was informed of the situation, what had happened in line with duty of candour practice policy and I also expressed my sincere apology." "This whole situation made me feel greatly disappointed in myself, in allowing such an oversight to happen when I realised this the next day. This realisation also made me feel helpless, demoralised, since it is my duty of care to primarily safeguard my service users and promote their health. The fact that this had already happened made me hopeless and remorseful. Despite this incident not resulting in any significant harm to service sure X's health and well-being I am aware that would result in disappointment loss of confidence and trust of my clinical competency by both the clinical lead team, the patient and service user family."

"The good thing that happened was that it did not cause any significant harm to the service user but it could have led to a serious case of hypotension, which could have led to death. Another good thing that happened was upon the realisation that the day staff immediately escalated the situation and effectively followed the Doctors advise to monitor her BP, which I was able to do the same throughout the night. In order to maintain the patient health safety and well-being. Therefore, highlighting the entire multidisciplinary team (MDT) involved upheld their duty of care and candour effectively. I was also afforded a debrief meeting to investigated what had happen to result in this drug administration error occurring. The tone of the meeting was not punitive, but rather supportive. The outcome of this brief outlined an action plan to help support me in my drug administration and management competency to eliminate incidents such as these in the future. Conversely, despite all the positive measures implemented, service user X was

subjected to undue harm, stress or potential long-term effects this situation, which could have been avoided if I had done the right checks by effectively performing the standard operating procedure in my drug administration."

"The overdosing of isosorbide mononitrate was a sincere mistake, which I will forever be remorseful about. From reflecting to the events that led to this incident it is some factors were clearly unavoidable. Such as tight time constraints due to limited staff resources. therefore, resulting in disproportionate and unsafe patient to staff ratios. Also as highlighted the dosage on the MAR chart was illegible making it difficult to read the prescription clearly. Its probable this could have led to misreading of the chart on my behalf. Hence why, National Patient Safety Agency (2010) argues, that poor prescriptions and limited resources results in ten times as much drug errors in comparison to human error or other factors. From doing this reflection it gave me the knowledge to stop and think what I did wrong and how I could have done it better to improve the care given to service users. It pointed out why I need to double check all the medications before I give them to the service user, to also read the written notes at the bottom and gave me knowledge and awareness of practice policy in addressing prescription discrepancies. By double checking I will be following the NMC standard for medicine management, which explains the 8 rights of administering medication e.g. right patient, right drug, right dose, right route, right time, right documentation, right reason and respond (NMC, (2019). This includes checking the name on the prescription chart, asking the service users name or date of birth and checking their room number or the name on their door. At the same time will check the label of the box if it is correct and in date. I will always use the BNF book to look for any medication I am not sure of and follow the home policy."

"In line with NMC code (2018) part 6 of Safety of Nursing Practice stating that "always practice in line with the best available evidence" I have taken the initiative to address my clinical limitation in drug and medication administration and management, I have done online training and I got certificates for introduction to

drug management and administration. I have also read the NICE and Royal College of Nursing (RCN) guidelines to help me understand the situation. Effective consideration of the highlighted evidence facilitated my employer and myself to implement an appropriate action plan which included following a period of shadowed drug administration rounds for support and confidence building. Where I would be implementing my 8 rights as per clinical policy, (NMC, 2019) in drug administration. If the similar situation rises again, I would inform the clinical lead, fill the medication error paperwork and make sure the GP has been informed of the incident and follow his instructions."

68.In relation to Patient C Ms Chipindiko stated:

"During this incident I was scared, since the patient was actively deteriorating despite any intervention implemented. In effort to manage the situation I employed another registered nurse input and insight to manage this situation. I was worried and afraid that patient was going into hypoxic cardiac arrest. With this consideration there was an element of panic in my action in placing a call out for the paramedics. Despite the patient being not for readmission in hospital and not for resuscitation I did not want her to have a hypoxic cardiac arrest that's why the paramedics were rang. I felt I was working in the best interest of the patient and safeguarding their health and safety. Despite the professional outcome of this incident on my part I feel my actions to address the presented patient deterioration prevented severe harm or death towards the patient."

"The good thing that happened was that it did not cause any significant harm to the service user but it could have led to carbon dioxide retention and subsequent hypoxic cardiac arrest, which could have led to death. Immediate response of the paramedics was effective and timely. They managed to restore stability in the patient's vitals and aware of the plan of care not to re admit the patient back into hospital. Conversely, there was an oversight on my part, I should've followed protocol to seek medical advice from the on-call doctors via the 111 call line.

Oxygen therapy was increased from to 2 to 3 litres despite not being prescribed. Seeking out advice would have clarified and informed my action in this situation. Therefore in hindsight I am aware my actions did not follow standard operating procedure, and deemed practising outside my professional scope."

"From reflecting to the events that led to this incident it is some factors were clearly unavoidable. Such as tight time constraints due to limited staff resources. therefore, resulting in disproportionate and unsafe patient to staff ratios. Communication on escalation procedure was vague considering I was relatively new at this care home and the other permanent nurse couldn't offer significant advice on how to address this situation hence why the paramedics was called out. From doing this reflection it gave me the knowledge to stop and think what I did wrong and how I could have done it better to improve the care given to service users. It pointed out why I need to improve my awareness of the SOP's with situation of patient clinical escalation. To involve the MDT in decision making, allowing me to practice within my clinical scope of practice. This reflection also improved my overall insight of managing resuscitation statuses and what they mean."

"In line with NMC code (2018) part 6 of Safety of Nursing Practice stating that "always practice in line with the best available evidence" I have taken the initiative to address my clinical limitation in oxygen therapy management. I have also read the introduction to oxygen therapy management on National Institute for Health and Care Excellence (NICE) (2019) and Royal College of Nursing (RCN) guidelines to help me understand the situation. Thus, improving my insight and awareness of the highlighted clinical status of don't attempt resuscitation (DNAR) in relation patient escalation in event of acute clinical deterioration. If the similar situation rises again, I would seek out appropriate advice, inform the clinical lead, fill the medication error paperwork and make sure the GP has been informed of the incident and follow his instructions."

69.Ms Chipindiko has provided some insight with regards the incidents involving Resident A, and Patients A, B and C. Ms Chipindiko has stepped back from the situations and recognised what went wrong on her part. Ms Chipindiko does part some blame regarding the errors that she made, for example that the medication records were not clear. But this does not mitigate Ms Chipindiko's overriding duty to ensure that the correct medication is administered accordingly, and where necessary seeking advice if there is ambiguity in the records to ensure that the correct medication is administered.

70.The panel may regard Ms Chipindiko's insight lacking in some areas and therefore requires further development. For example, Ms Chipindiko does not provide any insight that the incidents have on the wider public interests and the importance of maintaining standards and confidence in the professions, and this includes a lack of insight regarding the importance of maintaining accurate records ensuring that risk of harm is avoided thereafter.

71.The parties accept that there remains a risk that the concerns could be repeated and that this risk extends to there being a risk that harm could be caused to members of the public and/or patients.

Public protection impairment

72.A finding of impairment is necessary on public protection grounds.
Public interest impairment
73.A finding of impairment is also necessary on public interest grounds.
74.In CHRE v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)
Cox J commented as follows at paragraphs 71, 74 and 75:

71. "It is essential, when deciding whether fitness to practise is impaired, not to lose

sight of the fundamental considerations… namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession .."

74. "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."

75. "I regard that as an important consideration in cases involving fitness to practise proceedings before the NMC where, unlike such proceedings before the General Medical Council, there is no power under the rules to issue a warning, if the committee finds that fitness to practise is not impaired. As Ms McDonald observes, such a finding amounts to a complete acquittal, because there is no mechanism to mark cases where findings of misconduct have been made, even where that misconduct is serious and has persisted over a substantial period of time. In such circumstances the relevant panel should scrutinise the case with particular care before determining the issue of impairment."

75.Having regard to the serious nature of the concerns identified, and the principles referred to above, a finding of impairment is necessary on public interest grounds. As recognised above, an important consideration is that a finding of no impairment would lead to no record of these regulatory charges and the conduct being marked, which would be contrary to the public interest.
76.The public would be concerned about the serious failings and Ms Chipindiko's competence in this case. The concerns are serious in nature and the need to protect the wider public interest calls for a finding of impairment not only to uphold the standards of the profession, but also to maintain confidence in the profession

and the NMC as its regulator. Without a finding of impairment, public confidence in the profession and the NMC would be undermined.

77. The Parties agree that Ms Chipindiko's fitness to practice is impaired on public protection and public interest grounds.

Sanction

78. Whilst sanction is a matter for the panel's independent professional judgement, the Parties agree that the appropriate sanction in this case is a Conditions of Practice Order for a period of 2-years with a review. This type of order would be the most appropriate and proportionate sanction to impose because it accurately reflects the concerns identified.

79. In reaching this agreement, the Parties considered the NMC's Sanctions Guidance ("the Guidance"), bearing in mind that it provides guidance and not firm rules. The panel will be aware that the purpose of sanctions is not to be punitive but to protect the public and public interest. The panel should take into account the principle of proportionality and it is submitted that the proposed sanction is a proportionate one that balances the risk to the public and the public interest with Ms Chipindiko's interests and rights to practice as registered nurse.

80. The aggravating features identified in this case are as follows:
• Evidence of patient harm in relation to Resident A
• Repeated conduct over a significant period of time
• Acting outside the scope of competency albeit attempting to act in Patient C's best interests
• Failure to seek clarification if documentation is unclear/ambiguous

81. The mitigating features identified in this case are as follows:
• Early admissions at local level and acceptance of the Regulatory Concerns

identified and investigated by the NMC.

• Remorse

• Some Insight demonstrated.

• With regards to some of the concerns, there was no evidence of actual patient harm albeit a risk of harm was apparent.

82.With regards to the Guidance, the following aspects have led the Parties to conclude that a Conditions of Practice Order is appropriate and proportionate. Taking the available sanctions in ascending order starting with the least restrictive:

A. Taking no action: *A Fitness to Practise Committee does have a discretion to take no further action and impose no sanction immediately after it has first decided that a nurse, midwife or nursing associate's fitness to practise is impaired and should only be used in rare cases. Because there is an ongoing risk regarding public protection, and the conduct undermined public trust, together with the fact that MsChipindiko breached a fundamental tenet of the profession, suggests that this type of sanction would not be appropriate or proportionate.*

B. Caution Order: *An order of this nature would only be appropriate if there were no ongoing risks to the public and/or patients requiring Ms Chipindiko's practice to be restricted, meaning that the conduct identified would be at the lower end of the spectrum of impaired fitness to practise. The parties accept that there remains an ongoing risk to the public and/or patients of harm being caused, and that the nature and seriousness of the concerns identified cannot be said to be at the lower of the spectrum of impaired fitness to practise.*

C. Conditions of Practice Order*: The concerns identified are clinical in nature and therefore any ongoing public protection risks associated with the concerns can be managed by the imposition of conditions. Patients will not be placed at risk either directly or indirectly because of the conditions, and patients will be protected at all*

times during the period that the conditions are in force. There are identifiable areas of within your clinical practice that can be addressed through workable, measurable and proportionate conditions such as record keeping, safe medication administration, patient observations, escalation and communication. There is no evidence of harmful deep-seated personality or attitudinal problems associated with Ms Chipindiko's practise. The parties agree that placing conditions on Ms Chipindiko's practice is proportionate and balances that of public protection with Ms Chipindiko's right to practise as a nurse.

The parties agree that the following conditions would provide adequate public protection and satisfy the public interest in this case:

1. You must limit your nursing practice to one substantive employer. This must not be an agency.

2. You must not be the sole nurse in charge of any shift.

3. You must not administer medication unless directly supervised by another registered nurse; until you have been assessed as competent to do so by another registered nurse.

4. You must ensure that you are supervised by another registered nurse any time you are working. Your supervision must consist of:
• Working at all times on the same shift as, but not always directly observed by another registered nurse.

5. You must work with your supervisor to create a personal development plan (PDP). Your PDP must address the concerns about
• medication administration;
• record keeping; and,
• communication and management in emergency situations.

You must:

a. Send your case officer a copy of your PDP before the next NMC review.

b. Meet with your supervisor at least every month to discuss your progress towards achieving the aims set out in your PDP.

c. Send your case officer a report from your supervisor before the next NMC review. This report must show your progress towards achieving the aims set out in your PDP.

6. You must keep the NMC informed about anywhere you are working by:

a. Telling your case officer within seven days of accepting or leaving any employment.

b. Giving your case officer your employer's contact details.

7. You must keep the NMC 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.

8. You must immediately give a copy of these conditions to:

a. Any organisation or person you work for.

b. Any employers you apply to for work (at the time of application).

c. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. You must tell your case officer, within seven days of your becoming aware of:

a. Any clinical incident you are involved in.

b. Any investigation started against you.

c. Any disciplinary proceedings taken against you.

10.You must allow your case officer to share, as necessary, details about your performance, your compliance with and/or progress under these conditions with:

a. current or future employer.

b. Any educational establishment.

c. Any other person(s) involved in your retraining and/or supervision required by these conditions.'

Here ends the provisional CPD agreement between the NMC and Mrs Chipindiko. The provisional CPD agreement was signed by Mrs Chipindiko on 30 April 2023 and the NMC on 31 May 2023.

Decision and reasons on the CPD

The panel decided to accept the CPD.

The panel heard and accepted the legal assessor's advice. He referred the panel to the 'NMC Sanctions Guidance' (SG) and to the 'NMC's guidance on Consensual Panel Determinations'. He reminded the panel that it could accept, amend or outright reject the provisional CPD agreement reached between the NMC and Mrs Chipindiko. Further, the panel should consider whether the provisional CPD agreement would be in the public interest. This means that the outcome must ensure an appropriate level of public protection, maintain public confidence in the professions and the regulatory body, and declare and uphold proper standards of conduct and behaviour.

The panel noted that Mrs Chipindiko admitted the facts of the charges. Accordingly the panel was satisfied that the charges are found proved by way of Mrs Chipindiko's admissions as set out in the signed provisional CPD agreement.

Decision and reasons on impairment

The panel then went on to consider whether Mrs Chipindiko's fitness to practise is currently impaired. Whilst acknowledging the agreement between the NMC and Mrs

Chipindiko, the panel has exercised its own independent judgement in reaching its decision on impairment.

In respect of lack of competence the panel determined that Mrs Chipindiko's fitness to practise is currently impaired on the ground of public protection and is also otherwise in the wider public interest.

In this respect, the panel endorsed paragraphs 72 to 74 of the provisional CPD agreement in respect of lack of competence.

Decision and reasons on sanction

Having found Mrs Chipindiko's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

The aggravating features identified in this case are as follows:

- Evidence of patient harm in relation to Resident A
- Repeated conduct over a significant period of time
- Acting outside the scope of competency albeit attempting to act in Patient C's best interests
- Failure to seek clarification if documentation is unclear/ambiguous

The panel also took into account the following mitigating features:

- Early admissions at local level and acceptance of the Regulatory Concerns identified and investigated by the NMC.

- Remorse
- Some Insight demonstrated.
- With regards to some of the concerns, there was no evidence of actual patient harm albeit a risk of harm was apparent.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Chipindiko's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.*' The panel considered that Mrs Chipindiko's lack of competence 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.

The panel next considered whether placing conditions of practice on Mrs Chipindiko's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*

- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that Mrs Chipindiko would be willing to comply with conditions of practice.

The panel noted that the incidents are remediable and Mrs Chipindiko has developed insight into her lack of competence, has provided reflection, is currently on a personal development plan (PDP) and her current manager has provided testimonial regarding her progress in the role. The panel noted that there has been no concerns since the incidents in question. The panel was of the view that it was in the public interest that, with appropriate safeguards, Mrs Chipindiko should remain practising as a nurse.

Balancing all of these factors, the panel agreed with the CPD that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mrs Chipindiko's case because she has been engaging with the process, has demonstrated remorse and developed insight. The panel also noted that Mrs Chipindiko is currently working as a nurse and her manager stated that she is progressing in the role whilst having the support she needs by way of a PDP.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel agreed with the CPD that the following conditions are appropriate and proportionate in this case:

'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 limit your nursing practice to one substantive employer. This must not be an agency.

2. You must not be the sole nurse in charge of any shift.

3. You must not administer medication unless directly supervised by another registered nurse; until you have been assessed as competent to do so by another registered nurse.

4. You must ensure that you are supervised by another registered nurse any time you are working.

   Your supervision must consist of:

   • Working at all times on the same shift as, but not always directly observed by another registered nurse.

5. You must work with your supervisor to create a personal development plan (PDP). Your PDP must address the concerns about

   • medication administration;
   • record keeping; and,
   • communication and management in emergency situations.

   You must:

   a. Send your case officer a copy of your PDP before the next NMC review.

b. Meet with your supervisor at least every month to discuss your progress towards achieving the aims set out in your PDP.

c. Send your case officer a report from your supervisor before the next NMC review. This report must show your progress towards achieving the aims set out in your PDP.

6. You must keep the NMC informed about anywhere you are working by:

a. Telling your case officer within seven days of accepting or leaving any employment.

b. Giving your case officer your employer's contact details.

7. You must keep the NMC 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.

8. You must immediately give a copy of these conditions to:

a. Any organisation or person you work for.

b. Any employers you apply to for work (at the time of application).

c. Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. You must tell your case officer, within seven days of your becoming aware of:

a. Any clinical incident you are involved in.

b. Any investigation started against you.

c. Any disciplinary proceedings taken against you.

10.You must allow your case officer to share, as necessary, details about your performance, your compliance with and/or progress under these conditions with:

a. current or future employer.

b. Any educational establishment.

c. Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for two years.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mrs Chipindiko has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Mrs Chipindiko's attendance at the review hearing, or if held as a meeting a reflective piece demonstrating your learning and progress
- A record of your continued engagement with the NMC
- Any relevant testimonials
- Evidence of any training undertaken and competencies achieved

This decision will be confirmed to Mrs Chipindiko in writing.

Decision and reasons on interim order

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 is in Mrs Chipindiko's own interests. The panel heard and accepted the advice of the legal assessor.

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interests. 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 agreed with the CPD that the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months. This will cover any appeal period and in the interim protect the public and address the wider public interest.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mrs Chipindiko is sent the decision of this meeting in writing.

That concludes this determination.