Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday 24 October– Wednesday 8 November 2023

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

Name of Registrant:	Farayi Louisa Mutasa
NMC PIN	20H1559E
Part(s) of the register:	Registered nurse – sub part 1 Adult nursing, level 1 – 16 November 2000
Relevant Location:	Lambeth
Type of case:	Lack of competence
Panel members:	Adrian Blomefield (Chair, lay member) Esther Craddock (Registrant member) Andrew Macnamara(Lay member)
Legal Assessor:	Justin Gau / Peter Jennings
Hearings Coordinator:	Catherine Acevedo / Hazel Ahmet
Nursing and Midwifery Council:	Represented by Honor Fitzgerald, Case Presenter
Ms Mutasa:	Present and represented by Dan Santos-Costa, Counsel instructed by the Royal College of Nursing (RCN)
Facts proved by admission:	11a
Facts proved:	Charges 1a, 1b, 1c, 2c, 3a, 3b, 4, 5a, 5b, 5c, 11b, 12a, 12b, 13, 14a, 14b, 14c
Facts not proved:	Charges 2a, 2b, 15

	Charges 6, 7, 8, 9, 10 withdrawn by the NMC
Fitness to practise:	Impaired
Sanction:	Conditions of Practice Order (12 months)
Interim order:	**Interim conditions of Practice Order (18 months)**

Details of charge

That you, between 30 November 2020 and 6 April 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse:

1. Between January to April 2021, on one or more occasions:
    a. Did not offer to wash patient/s and/or did not carry out personal care to patients assigned to your care; ***Proved***
    b. Did not complete a fluid balance chart as required for an unknown patient; ***Proved***
    c. Failed to escalate that an unknown patient was retaining urine. ***Proved***

2. Between 30 November 2020 to 31 March 2021 you:
    a. Did not carry out covid-19 swabs on unknown patient/s allocated to your care; ***Not proved***
    b. Did not complete a PICC line dressing change for unknown patient/s allocated to your care and/or did not escalate that the PICC line dressing would not be completed during your shift; ***Not proved***
    c. Did not administer the prescribed dosage of FFP and/or did not escalate that an unknown patient required additional FFP to be administered. ***Proved***

3. Between 30 November 2020 to 31 March 2021 you:
    a. Did not answer a call bell and/or failed to assist an unknown patient move from their commode; ***Proved***
    b. Did not change the bedding of an unknown patient. ***Proved***

4. Your actions at charges 2 and 3 failed to prioritise the care of your patients. ***Proved***

5. On 3 January 2021 you:

a. Failed to provide a clinical overview of the patients assigned to your care, when asked; ***Proved***
b. Failed to complete observations of the patients assigned to your care; ***Proved***
c. Failed to identify that unknown patient/s assigned to your care were in respiratory distress. ***Proved***

6. ***Charge withdrawn by the NMC***

7. ***Charge withdrawn by the NMC***

8. ***Charge withdrawn by the NMC***

9. ***Charge withdrawn by the NMC***

10. ***Charge withdrawn by the NMC***

11. On 24 March 2021 you:
    a. Did not respond to a call bell from an unknown patient; ***Proved by admission***
    b. Delayed the administration of an enema to an unknown patient. ***Proved***

12. On 29 March 2021, in regards to an unknown patient, failed to:
    a. Ensure that a sliding scale was administered on an unknown patient. ***Proved***
    b. Escalate an unknown patient with a NEWS score over 7. ***Proved***

13. Between January 2021 to April 2021, you endeavoured to administer a nebuliser to an unknown patient without a prescription. ***Proved***

14. On 6 April 2021 you:
    a. Did not carry out observations on an unknown patient; ***Proved***

b. Did not monitor blood glucose on an unknown patient; ***Proved***

c. Did not complete fluid balance chart/s and/or bedside charts for patients assigned to your care. ***Proved***

15. Your action/s at charge 14a, 14b and/or 14c failed to prioritise tasks. ***Not proved***

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

Background

On 30 November 2020, you commenced employment at King's College Hospital NHS Foundation Trust (the Trust) as a newly qualified registered nurse. Your supernumerary period had finished and from the 22 December 2020 you started working as a registered nurse.

You were predominantly placed to work on Howard Ward (the Ward), where you had previously completed a few months of your student management placement. The Ward is a 16 bedded general hepatology ward, split into three bays in addition to side rooms for infectious patients, and a safety room for patients with mental health problems. The Ward provides care to both male and female patients and specialises in hepatology. The Ward's area of specialism is complex and, on some occasions, there are surgical patients on the Ward, including transplant patients.

In addition to the Ward, you also spent some of your time working on Todd Ward and Dawson Ward. Todd Ward specialises in liver transplants and Dawson Ward specialises in Hepato-Pancreato-Biliary ('HPB') surgery. When you started your role, you were assigned to complete a two-three day Trust induction and a three day NMC induction training.

On 30 November 2020, you joined the Ward in a supernumerary role, which is normal for all newly qualified nurses on the Ward. The supernumerary period placed you in a learning role, in which you can complete your induction and are supervised by mentors during each shift.

Following this, you were deemed able to work independently but remained supervised for intravenous ('IV') medications as you had not completed the assessment for this competency. You were added to the numbers of each shift, meaning that you were no longer an additional staff member to be supervised on the Ward, but a staff member responsible for the care of your own patients.

On 3 January 2021, the Ward received Covid-19 positive patients. However, when Witness 6 asked you for an update you were allegedly unable to provide them with a clinical overview of your patients. When Witness 6 went to the bay themselves, they found two of your patients in severe respiratory distress and not receiving proper oxygen therapy, which the evidence suggests that they required at the time. It is alleged you appeared not to be aware of your new patients and their clinical state. From this point on concerns were regularly raised by multiple members of staff. These included:

- Failures to provide care to patients in that you did not attend to, or delayed attending to, patients in respect of personal care tasks and conducting observations;
- Failures in medication management and administration;
- Failures to recognise and escalate deteriorating patients;
- Failures to prioritise workload; and
- Lack of empathy and compassion towards patients.

As such, the Ward Manager Witness 1, decided to move you to Todd and Dawson Wards and the Practice Development Nurse, Witness 2, provided you with additional support during your shifts.

The Ward returned to a care ward and so it was decided you would return. On 15 February 2021, during your first probationary review, concerns were raised with regard to your performance. As such, a decision was made to extend your probationary period to June 2021. During the meeting, Witness 1 decided to implement an action plan for you with the following objectives:

- prioritise tasks, including planning for the day and monitoring medication administration and documentation;
- work on communication and attitude towards patients and colleagues;
- work on reflection and learning from this.

[PRIVATE]

[PRIVATE]

You and Witness 1 discussed ongoing concerns with regard to your practice. You said that you were unhappy that communication with colleagues was part of your action plan as you felt you were "being bullied and that the Ward was a toxic environment with an element of institutionalised bullying".

On 6 April 2021, Witness 1 took the decision to return you to supernumerary status and for the period of your action plan to be extended for a further four weeks.

[PRIVATE]

In June 2021, Witness 1 compiled an "end of probation report" setting out your time on the Ward and the concerns raised with regard to your practice and performance. Witness 1 concluded that your probationary period had been unsuccessful and recommended that the matter proceed to a final probationary review hearing.

The hearing took place on 11 August 2021. Following this, the Trust decided to dismiss you on the grounds of capability as you had failed your probationary period. You appealed their dismissal. The appeal was not upheld.

Decision and reasons on application to admit the written statement of Witness 2

The panel heard an application made by Ms Fitzgerald under Rule 31 to allow the written statement of Witness 2 into evidence. Witness 2 was not present at this hearing and, whilst the NMC had made efforts to ensure that this witness was present, she was unable to attend due to health reasons.

Ms Fitzgerald referred the panel to an email and [PRIVATE] sent by Witness 2 on 16 October 2023 which stated that she will not be able to participate in the hearing on 24 -25 October 2023.

Mr Santos-Costa submitted that you were only notified that Witness 2 would not be attending the previous week and the panel must consider whether there is good reason for her non-attendance. It must also consider whether the NMC has taken all reasonable steps to secure her attendance. He submitted that there is no evidence to say that Witness 2 is unfit medically to attend the hearing. He submitted that the NMC have not looked into special measures to secure Witness 2's attendance.

Mr Santos-Costa submitted that Witness 2's statement is demonstrably unreliable, and her evidence is the sole and decisive evidence in relation to a number of the charges. He submitted that there is no corroborating material from Witness 1 and that all the material comes from Witness 2. Mr Santos-Costa submitted that it would not be fair to you to admit Witness 2's statement as her evidence cannot be tested and the application to allow Witness 2's statement should fail.

The panel asked Ms Fitzgerald to enquire what further communication has been made with Witness 2 and whether she can be contacted and asked to attend the hearing virtually on 26 - 27 October 2023.

Ms Fitzgerald made enquiries, and informed the panel that it was always intended for Witness 2 to attend virtually. She submitted that it is the NMC's position that [PRIVATE], it would be inappropriate to ask Witness 2 to attend and the NMC do not wish to push her any further. She submitted that any challenges by the defence can be properly dealt with by Witness 1. In relation to the evidence that only Witness 2 can give evidence to, she submitted that those issues can be overcome in terms of the weight the panel deems appropriate once it has heard and evaluated all the evidence before it.

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

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 2 to that of a written statement.

The panel saw no evidence from the NMC that they had made further efforts to secure Witness 2's attendance or suggested any special measures. It noted the NMC has simply accepted the email and [PRIVATE] at face value.

It considered that Witness 2 was the primary witness to some of the events and provided the only evidence in relation to a number of the charges. It considered that if Witness 2's evidence were admitted, you would not be able to challenge the evidence.

The panel therefore concluded that it would be prejudicial to accept into evidence the written statement of Witness 2.

In these circumstances the panel refused the application.

After the panel announced its decision on this application, Ms Fitzgerald informed the panel that the NMC would be offering no evidence on charges 6, 7, 8, 9 and 10 in their entirety.

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

Mr Santos-Costa made a request that any reference to your health be held in private. He also requested that any previous references to your health be marked as private in the transcript. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Fitzgerald indicated that she supported the application.

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

Having heard that there may be further references to your health, the panel determined to hold those parts of the hearing in private and directed that any reference to your health be marked as private in the transcript.

Abuse of process application in relation to charge 2a and no case to answer in relation to charges 1c, 2a, 11b and 12b

After the close of the NMC's case, Mr Santos-Costa submitted that the lack of specificity of the allegations, makes it impossible for you to answer the case that you face. It is

submitted that charge 2(a) breaches Article 6(3)(a) of the European Convention for Human Rights (ECHR).

Accordingly, Mr Santos-Costa submitted that it will be impossible for you to have a fair trial in respect of this charge, and the charge ought to be stayed forthwith to preserve the fairness of these proceedings.

The power to stay proceedings is established within the case of *Maxwell* [2011] UKSC 48. In his judgment, Lord Dyson held at paragraph 13:

> *"It is well established that the court has the power to stay proceedings in two categories of case, namely (i) where it will be impossible to give the accused a fair trial, and (ii) where it offends the court's sense of justice and propriety to be asked to try the accused in the particular circumstances of the case. In the first category of case, if the court concludes that an accused cannot receive a fair trial, it will stay the proceedings without more. No question of the balancing of competing interests arises. In the second category of case, the court is concerned to protect the integrity of the criminal justice system. Here a stay will be granted where the court concludes that in all the circumstances a trial will "offend the court's sense of justice and propriety" (per Lord Lowry in R v Horseferry Road Magistrates' Court, Ex p Bennett [1994] 1 AC 42 , 74G) or will "undermine public confidence in the criminal justice system and bring it into disrepute" (per Lord Steyn in R v Latif and Shahzad [1996] 1 WLR 104 , 112F).*

Article 6(3) of the European Convention for Human Rights stipulates:

> *a. to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;*
>
> *b. to have adequate time and facilities for the preparation of his defence;*

c. to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;

d. to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;

e. to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

The principles set out in Articles 6(2) and 6(3)(a), (b), and (d) are applicable *mutatis mutandis* to disciplinary proceedings subject to Article 6(1) in the same way as in the case of a person charged with a criminal offence. (*Albert and Le Compte v Belgium* (1983) 5 E.H.R.R. 533, § [39]).

"The test to be applied in these cases is a two-stage test. Firstly, whether the challenges in the circumstances of the case provided sufficient information to enable those charged to know, with reasonable clarity, the case they have to meet. Secondly, whether they know enough about the charges to enable them to prepare their defences. The second stage of the test is: if the first stage is not satisfied whether the only remedy is a stay": R(Johnson) v NMC [2008] EWHC 885 (Admin) per Beatson J at [102].

Mr Santos-Costa submitted that if the panel does not consider that a stay is an appropriate remedy, it may consider at this stage that there is no case to answer and dismiss charge 2a. He submitted that there is no case to answer because the evidence is inherently weak and vague. He submitted that no tribunal, properly directed, could find these charges proved therefore, the panel ought to dismiss charge 2a.

Mr Santos-Costa made a further application of no case to answer in relation to charges 1c, 11b and 12b.

In relation to charge 1c, Mr Santos-Costa submitted that charges 1b and 1c are ‘mutually exclusive’. He submitted that in order to escalate that the patient was retaining urine you would need to know about it. He submitted that if you did not know what you were escalating, you would not have a duty to escalate it. He submitted that the duty would arise if you had knowledge of the fluid balance chart, and it is the NMC’s case that you did not complete the fluid balance chart. He therefore submitted that there is no evidence to support the charge at this stage.

In relation to charge 11b, Mr Santos submitted that there is no evidence to support that you delayed the administration of an enema. He submitted that to ‘delay’ is an intentional act and there is no evidence that you intentionally delayed the administration of an enema to a patient. He submitted that the NMC’s case taken at its highest is that you were asked to do it and had not done it. He therefore submitted that there is no evidence to support the charge.

In relation to charge 12b, Mr Santos-Costa submitted that it is clear that you did not know the NEWS score was over 7, therefore, how could you have escalated this? He submitted that there is no evidence to support the charge.

Dealing firstly with charge 1a and the abuse of process application, Ms Fitzgerald submitted that you only worked 22 shifts between November - February and then March - April 2021. She submitted that the panel is ‘aware of the dates, the Ward and it has heard from Witness 3, who was the other nurse involved’. Ms Fitzgerald accepted that the patient’s name is not known but this does not come close to being a breach of the Article 6 process. She submitted that there is a great deal of detail and the evidence from Witness 3 is sufficient for you to understand the charge you are facing and the high bar of abuse of process has not been met.

In response to the application of no case to answer in respect of charge 1c, Ms Fitzgerald submitted that charge 1c is not mutually exclusive to charge 1b. She submitted that the

fluid balance chart is not the only way a nurse would know that a patient is retaining urine and you could have spoken to the patient and asked them. She submitted that these are two separate charges and the fact that the fluid balance chart was not completed does not mean that you did not have a duty to escalate that the patient was retaining urine. She therefore submitted that there is a case to answer for charge 1c.

In relation to charge 11b, Ms Fitzgerald submitted that the panel has heard evidence from Witness 5 that she said she asked you to check on the patient in bed 8 and give them an enema. Witness 5 later asked you if you had given the enema and you said you had not, and no reason was given. Ms Fitzgerald submitted that there is a delay if you are asked by someone in a more senior position to you to do something and you do not do it immediately. She submitted that you would have been aware why an enema was required and why Witness 5 would have asked you repeatedly and would have been apparent that it was urgent. She therefore submitted that there is a case to answer for charge 11b.

In relation to charge 12b, Ms Fitzgerald submitted that there is a duty to check on your patients to see what they look like and whether they are showing signs of deterioration and in addition to check the computer where it would have told you the NEWS score of 7. She submitted that it was your responsibility to check on your patients especially before going on a break. She therefore submitted that there is a case to answer for charge 12b.

Ms Fitzgerald submitted that there is sufficient evidence in respect of charges 1c, 11b and 12b on which the panel can find the charges proved.

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

In relation to the abuse of process application, the panel considered the application that the charges are not sufficiently particularised and lack specificity. The panel looked at the timing of the charge and noted that although it its broadly drafted between 30 November

and 31 March 2021, the evidence is that the actual time period when you would have worked with Witness 3 was much narrower than that.

The panel was therefore satisfied that you should be able to understand the nature of the charge you are facing in respect of charge 2a. The panel accepted that there was nothing to corroborate Witness 3's evidence but the weight it gives to any evidence remains to be determined at the conclusion of all the evidence.

The panel therefore rejected the application of abuse of process in relation to charge 2a.

The panel then went on to consider the no case to answer application, the panel made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer in respect of charges 1c, 2a, 11b and 12b.

In relation to charge 2a, the panel considered Witness 3's evidence to be credible and reliable. The panel found Witness 3's evidence to be balanced and it saw no evidence of her having any animosity towards you. The panel considered that her evidence spoke specifically to charge 2a. It therefore considered that there was sufficient evidence for the panel to determine there is a case to answer in respect of charge 2a.

In relation to charge 1c, the panel considered that there was sufficient evidence from the account of Witness 4 who was directly involved in the incident. The panel did not consider that charge 1c and 1b were mutually exclusive. It therefore determined that there was sufficient evidence for the panel to find there is a case to answer in respect of charge 1c.

In relation to charge 11b, the panel considered that there was sufficient evidence from the account of Witness 5 who was directly involved in the incident. It therefore determined that there was sufficient evidence for the panel to find there is a case to answer in respect of charge 11b.

In relation to charge 12b the panel considered that there was sufficient evidence for the account of Witness 6 who was directly involved in the incident. It therefore determined that there was sufficient evidence for the panel to find there is a case to answer in respect of charge 12b.

The panel was of the view that there had been sufficient evidence to support charges 1c, 2a, 11b and 12b at this stage and, as such, it was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Fitzgerald on behalf of the NMC and by Mr Santos-Costa on your behalf.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: [PRIVATE]
- Witness 3: [PRIVATE]
- Witness 4: [PRIVATE]
- Witness 5: [PRIVATE]

- Witness 6: [PRIVATE]

The panel also heard evidence from you under oath.

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

The panel were very aware that there is very little independent contemporaneous evidence available to it. There are, for example no patient notes and no Datix records. The panel have taken this into account in relation to the weight they can give to the evidence they have heard. The panel did note that a few contemporaneous pieces of evidence, namely the action plans, repeatedly made reference to basic failures in fundamental aspects of nursing. The comments on the action plans were drafted by different nurses on different days. They also took into account the amount of shifts you actually worked when they considered the weight they could give to the written and oral evidence that they have considered.

You now face a total of 10 allegations including 18 sub-allegations between 30 November 2020 and 6 April 2021 when you were working on Howard Ward. In truth, though, you were working as a fully qualified nurse on the Ward for much less time than this.
On 30 November 2020, you joined the Ward in a supernumerary role, which is normal for all newly qualified nurses on the Ward. You were supervised at all times.

You started to work as a qualified nurse on 22 December 2020 only working the Ward until the 4 January 2021. As Howard ward had become a Covid ward you were then redeployed to Todd and Dawson wards from then until the 3 February. You went on holiday from 5 February to the 15 February

You worked from the 15 to 16 February. [PRIVATE].

You worked a total of only 22 shifts between 30 November 2020 and 11 August 2021. The panel find your repeated assertions that you have no recollection of what must have been significant events on the few occasions you were working as inconceivable. The events in question appear to be clearly remembered by your more experienced and busier colleagues.

The panel also noted your oral evidence when you were asked what you expected a Healthcare Assistant (HCA)'s duties on the Ward were, with your long experience of being an HCA. You stated:

> *"When I was trained in a hospital setting I would do as delegated, I would deal with patient's hygiene and feeds, and also other roles such as observations and report irregular readings, I would also do fluid charts, and anything else I was trusted to do."*

The panel feel that you regarded the role of HCA's on the Ward in the same way. This informed your behaviour.

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

Charge 1a

That you, between 30 November 2020 and 6 April 2021 failed to demonstrate the standards of knowledge, skill, and judgement required to practise without supervision as a band 5 nurse:

1. Between January to April 2021, on one or more occasions:
    a. Did not offer to wash patient/s and/or did not carry out personal care to patients assigned to your care;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4.

Your evidence is that you have no recollection of this incident.

Witness 4 said in her local statement dated 1 April 2021 *"In that shift we were short by one HCA. I realised Farayi's patient's bedsheets were not changed, and they looked messy. There were dirty pads on the floor and the whole bay was neglectful. I asked her if she offered a wash to any of her patients that morning and she said she did not have time. I did not understand how she did not have the time to be involved in personal care if she was not doing either observations or medication, as I was doing that for her. I asked her to maintain the dignity of her patients and to tidy up the mess. As I did not see the initiative on her, it was me who end up doing it".*

This was consistent with Witness 4's witness statement and oral testimony and handwritten notes on the action plan dated 15 February 2021 which was signed by her.

The panel found Witness 4's evidence to be credible and reliable. The panel found her account of the incident to be sufficiently detailed. It noted that she described what she saw, the state of the bay, and she recalled being surprised and how she had addressed you on the importance of carrying out the tasks detailed in the charge. The panel was of the view that changing bed sheets and offering to wash patients as described by Witness 4 would fall under the description of 'personal care' and this was not carried out.

Having found Witness 4's evidence to be credible and reliable, the panel accepted her evidence. The panel found on the balance of probabilities that you did not offer to wash patients and did not carry out personal care to patients assigned to your care. It therefore found charge 1a proved.

Charge 1b

1. Between January to April 2021, on one or more occasions:
   b. Did not complete a fluid balance chart as required for an unknown patient;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 4.

Your evidence is that you have no recollection of this incident.

Witness 4 said in her local statement *"I explained her the importance of completing a fluid balance chart for the patients that required one due to medical condition, and she did not complete one for her patients when I checked at the end of the shift. As a nurse in charge, I could not rely on Farayi looking after her patients. In my opinion, it is a great challenge to do the nurse in charge duties and work with Farayi. At the end of that shift, I gave her some feedback and she seemed to listen to it".*

This was consistent with Witness 4's NMC witness statement and oral testimony. The panel also noted Witness 4's NMC witness statement that she had to escalate to the doctors the fact that the patient had not passed urine and they requested that the patient have an urgent catheterisation.

The panel found her account of the incident to be sufficiently detailed. It heard that Witness 4 had explained to you the importance of completing the fluid balance chart. Witness 4 also described what actions she had to take when she escalated that the patient had not passed urine to the doctors and the feedback that she gave you.

Having already found Witness 4 to be credible and reliable, the panel accepted her account of the incident. The panel found on the balance of probabilities that you did not

complete a fluid balance chart as required for the patient. It therefore found charge 1b proved.

Charge 1c

1. Between January to April 2021, on one or more occasions:
    c. Failed to escalate that an unknown patient was retaining urine.

This charge is found proved.

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

The submission made on your behalf was that a duty to escalate requires knowledge and it would therefore be illogical to owe a duty to escalate something of which you have no knowledge.

Witness 4 stated in her NMC statement *"Ms Mutasa should have completed the fluid balance chart as this was required for the patient, and had been handed over to Ms Mutasa at the beginning of the shift and requested by the doctors who needed to know the patients urine input and output, but instead they failed to complete any fluid monitoring at all. As a registered nurse, Ms Mutasa had a duty under Part 10 of the NMC Code to keep clear and accurate records, which they failed to do in not documenting their patients urine input and output as they were requested to at handover. I had also previously spoken to Ms Mutasa about the importance of fluid monitoring, during previous shifts, and at the time I felt that they had understood the importance of this, but this incident demonstrated that they had not retained this information, and failed to implement it in their practice".*

Having already found Witness 4 to be credible and reliable, the panel accepted her evidence. The panel also rejected the submission that you did not have a duty to escalate what you were not aware of. The panel considered that a competent practitioner would

have known that they had to escalate if a patient was retaining urine. Had you completed the fluid balance chart you would have been aware that the patient was retaining urine, and this should have been escalated but you failed to do so. The panel also accepted Witness 4's evidence that there were other ways of establishing whether the patient was retaining urine, such as by asking the patient. The panel noted that this is indeed how Witness 4 identified that the patient was retaining urine. So, the failure to escalate was not entirely dependent on completing the fluid balance chart.

The panel therefore found charge 1c proved.

Charge 2a

2. Between 30 November 2020 to 31 March 2021 you:
    a. Did not carry out covid-19 swabs on unknown patient/s allocated to your care;

This charge is found not proved.

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

The panel has already noted the few dates that you actually worked on the Ward.

Your evidence again, is that you have no recollection of this incident but provided oral testimony regarding what would have been your usual practice which was that the swabs would be collected and sent to the lab at a precise time in the morning.

Witness 3 said in her NMC witness statement *"Ms Mutasa would never get around to doing their tasks during their shift, so left them to the night shift staff instead. An example of this, which I recall was when a couple of Ms Mutasa's patients were due a Covid-19 swab, and after I continuously prompted them to do it, I found at the end of the shift the*

swabs had not been completed and Ms Mutasa instead handed this task over to the night shift staff".

The panel noted that this was also mentioned briefly in Witness 3's local statement. However, the panel considered Witness 3's evidence on this charge to be vague and non-specific.

The panel determined that it had not been provided with sufficient evidence to find that you did not carry out Covid-19 swabs on patients allocated to your care. The panel therefore found charge 2a not proved.

Charge 2b

2. Between 30 November 2020 to 31 March 2021 you:
    b. Did not complete a PICC line dressing change for unknown patient/s allocated to your care and/or did not escalate that the PICC line dressing would not be completed during your shift;

This charge is found not proved.

In reaching this decision, the panel took into account Witness 3's evidence and your evidence.

The panel accepted that on this day you had two patients handed over to you that needed PICC line dressings to be changed.

In relation to the first PICC line dressing, you accept that you did not do the PICC line dressing. You said in your written statement *"I alerted the nurse in charge [Witness 3] who told me that she was going to demonstrate how to do it. When I was ready, I went back to alert her that I was ready to change the dressing, she said she was busy, and she would inform me when she was ready and she sent me for tea break. When I came back from*

break I reminded her to assist me with the changing of the dressing, she responded by informing me that she had done it when she had a free moment when I was on my break and that she has asked another nurse to assist me with the second dressing change".

Witness 3 said in her local statement *"On the last few shift I did with Farayi she had two patient who needs a PICC line dressing changed according the handover she received. I reminded Farayi if the dressing was done and she said it was not done as she doesn't know how to change it. I told her I am busy now but when I get time I will show you how to do one dressing and you will do the other with my supervision. In which she agreed and went for tea break (15min) Meanwhile I managed to get time to do her dressing and realised that Farayi was still on break ~30 min…The ward gets busy and I was not able to show her the dressing on that occasion".*

The panel found your statement and Witness 3's statements in relation to the first patient to be broadly consistent. The panel therefore found on the balance of probabilities that you did not complete a PICC line dressing change for the patient allocated to your care.

In relation to the second PICC line dressing, you said in your written statement *"[Witness 3] has asked another nurse to assist me with the second dressing change. [The other staff nurse] said she would call me when she was ready to change the second dressing. Again, she did it without me. She said she was very busy and she got a moment and did it without me, but she would call me next time. At handover to night staff, [Witness 3] handed over that I had refused to do the dressing which was definitely not the case".*

Witness 3 said in her NMC witness statement *"As far as I recall, following this, Ms Mutasa did not come to me the whole shift with regard to the PICC line dressings. At one stage, I got some time so did one of the dressing changes myself. I think I asked Ms Mutasa to come and observe me do it, but I do not remember their response and do not recall them observing. When it got to the end of our shift and we were handing over to the night shift, I then heard Ms Mutasa hand over the second PICC line dressing change to another nurse,*

which they had still not completed". This was consistent with Witness 3's local statement and oral evidence.

The panel therefore found charge 2b not proved as drafted.

Charge 2c

2. Between 30 November 2020 to 31 March 2021 you:
    c. Did not administer the prescribed dosage of FFP and/or did not escalate that an unknown patient required additional FFP to be administered.

This charge is found proved.

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

Your said in your statement *"I was not competent to administer FFP and I have no recollection of this incident happening. Anything to do with intravenous medication was the responsibility of the nurse in charge of the shift".*

The panel acknowledged that you were not competent to administer FFP intravenously. However, it concluded that you had an overarching responsibility for the care of your patients, and this included ensuring that prescriptions were administered as prescribed.

Witness 3 said in their local statement *"Firayi came to me and said the FFP of my patient in finished can you flush is? I said fine; Later on when I went to check the fridge in the treatment room I found 1 pool of FFP for the same patient. Had I known there is more I would have given it to the patient. I went to Farayi and said Farayi you ask me to flush so I did. I there anything else you need me doing? She then remembered that there is another one needs to be given".*

The panel accepted Witness 3's evidence. It rejected your evidence that you were not meant to be involved in any part of the blood transfusion process. You had been informed about what FFP was required at handover and you had responsibility to check what had been administered from the patient record. The panel considered from all of the evidence that you should have been aware of the second bag and that it should have been escalated that the patient required additional FFP to be administered. The panel therefore found charge 2c proved.

Charge 3a

3. Between 30 November 2020 to 31 March 2021 you:
    a. Did not answer a call bell and/or failed to assist an unknown patient move from their commode;

This charge is found proved.

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

Witness 3 said in her NMC statement *"On this shift a HCA had given one of Ms Mutasa's patients a commode, however, soon after another patients had an accident and was bleeding, so the HCA left to attend to the other patient. As the patient was then alone, when they were finished with the commode they used their call bell to get assistance moving from the commode. I heard the bell going and could see Ms Mutasa standing at the computer right next to the bay, and not reacting to the call bell, which they would have been able to hear as it is loud enough for the whole Ward to hear, and the patient was calling for help too. I was in the middle bay assisting a bleeding patient, but responded to the call bell and assisted the patient moving from the commode. After assisting Ms Mutasa's patient, I went to them and asked why they did not attend their patient when they were calling, to which Ms Mutasa responded that I should ask the HCA who have assisted the patient with the commode. Ms Mutasa then said that they were focussing on medication, which was not due at that time (medications are started from 14:00, and this*

conversation took place at around 13:00), so should not have been a priority over a patient trying to get assistance."

Your evidence was that a call bell was ringing, although you did not know which patient it was and you denied that the patient was calling out. You said you recalled that Witness 3 attended the patient and that you were busy doing a drug round at the time. You denied that Witness 3 asked you why you were not attending your patient, and you denied telling Witness 3 to get one of the HCA's to assist.

In relation to the failure to assist an unknown patient move from their commode, you said that you were busy doing the drug round and that all nurses can respond to the call bell and assist any patient not just the nurse responsible for the patient.

The panel accepted Witness 3's evidence. The panel also took into account that you accepted that you had heard the call bell and not answered it. It considered that it was expected that any nurse regardless of whether the patient is allocated to them or not should prioritise this over tasks that do not need completing at that exact moment. The panel did not hear evidence that suggested that you were in the middle of administering medication but it heard that you were viewing a computer when the call bell rang, therefore, it had no supporting evidence that you were in the middle of a task that took priority over answering the call bell for your patient. The panel therefore found charge 3a proved.

Charge 3b

3. Between 30 November 2020 to 31 March 2021 you:
    b. Did not change the bedding of an unknown patient.

This charge is found proved.

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

Witness 3 said in her local statement *"When the patient came back from CT she had accident on the bed so the HCA gave her a commode at the bedside and ask Farayi if she could help her to make the bed. Farayi told her to go and ask for help as she is doing her drugs which was ~1300H".*

The panel accepted Witness 3's account of the incident. The panel also took into account that you accepted that you did not assist this patient and you asked the HCA to change the soiled bedding. The panel determined that you did not change the bedding of an unknown patient and found charge 3b proved.

Charge 4

4. Your actions at charges 2 and 3 failed to prioritise the care of your patients.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 3.

The NMC Witness statement of Witness 3 said *"This specific incident, and wider concern, was very serious as failing to prioritise patients put them at risk of harm. For example, for this incident, if the patient had continued to be ignored by Ms Mutasa and no one else attended, they may have tried to move themself which could have resulted in a fall".*

In respect of charge 2c, the panel considered by not ensuring that another qualified nurse administered the prescribed amount of FFP, it is clear you did not prioritise the care of your patient.

In respect of charge 3, the panel considered that you were focused on your medication round which was not due until 2pm. It was of the view that even in the event that the medication round was due between 12pm and 2pm it would have been a greater priority for you to respond to the call bell to establish what needed to be prioritised.

The panel heard from all of the NMC's witnesses who said that the call bell can be answered by anyone however, this charge involved your failure to prioritise patients.

The panel determined that your actions at charges 2c and 3 failed to prioritise the care of your patients and it therefore found charge 4 proved.

Charge 5a

5. On 3 January 2021 you:
    a. Failed to provide a clinical overview of the patients assigned to your care, when asked;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence.

Your evidence is that *"When [Witness 6] was updating the board, he wanted me to tell him some information about the patient in bed 9, I cannot exactly remember what that was, but he either asked me to tell him the patient's name or where he had come from. We never discussed any clinical matters about the condition of my patients. I could not answer him immediately as I needed to check it on my handover sheet".*

Witness 6 said in his witness statement *"At around 17:30, when most of the 16 Covid-19 positive patients had arrived on the Ward, I asked all staff nurses and HCA for a clinical overview of the patients they had received in the bay they were responsible for during that*

shift. I do not recall exactly how many patients I had allocated to Ms Mutasa, due to the passage of time, but as Nurse in Charge I would normally allocate five patients to new nursing staff, taking into consideration skill mix of staff on shift. The other staff nurses had provided me the clinical overview of all of their patients however, Ms Mutasa told me they did not know anything about their patients in their bay and suggested I speak to [the Matron]. I firstly found it strange that they would ask me to speak to the Matron, as their presence on the Ward was for operational purposes and they do not generally deal with bedside nursing. I was also very concerned that Ms Mutasa seemed to know nothing about the patients they were responsible for, suggesting that they had not taken handover when the patients arrived on the Ward from mid-day on".

The panel noted that Witness 6 and your accounts differ in that you said you were asked by Witness 6 for the patients' names and where they had come from but Witness 6 said that he asked you for a clinical overview of your patients.

The panel found Witness 6's evidence to be credible and reliable. His local statement, witness statement and oral evidence were all consistent. His account was detailed, he described the incident and his concern about you not knowing information about the patients in your care. Witness 6 admitted that he was upset when you had complained about his behaviour to you in this incident, but he reasserted the clarity of his recollection of the events of 3 January 2021. The panel preferred the evidence of Witness 6. It considered it was more likely than not that he asked you for a clinical overview of the patients which you could not provide. The panel considered that you were responsible for the patients in your bay and that, as one of the nurses on duty that shift, it was expected that you would be aware of who your patients were and their condition. The patients had arrived on the Ward that day without handover and therefore it would be expected that you would have evaluated their condition and be aware of their clinical needs and be able to give a clinical overview.

The panel determined that you failed to provide a clinical overview of the patients assigned to your care, when asked and therefore found charge 5a proved.

Charges 5b and 5c

5. On 3 January 2021 you:
    b. Failed to complete observations of the patients assigned to your care;
    c. Failed to identify that unknown patient/s assigned to your care were in respiratory distress.

These charges are found proved.

In reaching these decisions, the panel took into account the evidence of Witness 6 and your evidence.

The submission made on your behalf is that Witness 6's evidence is unreliable.

Witness 6 said in his witness statement *"After Ms Mutasa advised me that they did not know about their patients at around 17:30 on 3 January 2021, I went to the bay Ms Mutasa was responsible for to check on their patients. Once at the bay, I found that two of the Nurse's patients were in respiratory distress, struggling for oxygen, and that as Ms Mutasa had not attended to them, they were not receiving proper oxygen therapy as they required. Oxygen therapy is usually prescribed for Covid-19 patients, and the prescription allows for a registered nurse to adjust and titrate according to the patient's current vital signs and needs. This (the patients being in respiratory distress) was due to the fact that Ms Mutasa had not attended to the patients to take their clinical observations, so did not know that they were in respiratory distress. Clinical observations include the assessment of vital signs (temperature, heart rate, respiratory rate and blood pressure), Glasgow Coma Scale (GCS), level of consciousness (assessing whether the patient is alert, verbal, responsive to pain or unresponsive) and pain felt".*

Having already found Witness 6's evidence to be credible and reliable, the panel accepted his evidence. The panel considered that you were responsible for the patients in your bay,

as one of the nurses on duty that shift, and it was your duty to complete observations of your patients which can then be used to identify changes and deterioration and you failed to do so.

The panel determined that you failed to complete observations of the patients assigned to your care and failed to identify that unknown patients assigned to your care were in respiratory distress. It therefore found charges 5b and 5c proved.

Charge 11a

11. On 24 March 2021 you:
    a. Did not respond to a call bell from an unknown patient;

This charge is admitted and found proved.

The panel took into account that you admitted this charge but on a limited basis so decided to consider the evidence. In reaching this decision, the panel took into account the evidence of Witness 5 and your evidence.

Your evidence is that you accept that you did not answer the call bell but you said it was everyone's job because you work as a team. You said in your written statement *"I attended to him twice before [Witness 5] attended to him. When [Witness 5] responded to a call bell I was in a bay attending to patients in that bay. After, [Witness 5] had assisted the patient inside room 4, she came to me accusing me of ignoring my patients in an undermining manner. I explained what I had already done for the patient, but before I could finish explaining, she walked away as if to say I was not worth listening to. I never heard of this issue again as the shift ended well".*

Witness 5 said in her NMC witness statement *"The first specific incident of concern, on 24 March 2021, involved a patient in Room 4 on the Ward, who was allocated to Ms Mutasa for the shift. I recall that the patient had a severe ulcer and at the beginning of the shift*

was using their call bell, which can be heard across the Ward when rung, to get someone to come to them. I was very busy with my own patients, but noticed that no one was responding to the patients call bell so went to them myself. On my way to the patient I saw that Ms Mutasa was looking at the computer, however, I do not know what they were looking at. I said to Ms Mutasa, from about two to three metres away, that their patient was calling, but they did not respond, so I am not sure if they heard me".

Witness 5 stated in her oral evidence that she went to get the linens to change the patient's bedding and called you to tell you that your patient needed your help. She assumed you had heard her as you had turned your face towards her and she also assumed that you would be following her into the patient's room. You did not follow her.

The panel found Witness 5 to be a credible and reliable witness. The panel found her account of the incident to be detailed, she described how she had asked two new overseas nurses to help her and also how she told you afterwards that you need to check on your patients and that the incident gave her the impression that you did not want to help the patient. The panel accepted the evidence of Witness 5. It considered it was more likely than not that you heard the call bell but when you saw that Witness 5 was dealing with it, you decided not to help.

The panel therefore found charge 11a proved.

Charge 11b

11. On 24 March 2021 you:
    b. Delayed the administration of an enema to an unknown patient.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 5 and your evidence.

The panel first considered the definition of 'delay'. Delay has its ordinary Dictionary meaning; '*to cause to be late or to cause to happen at a later time, or to wait before acting*.'

Your evidence is that it was handed over to you that a patient needed an enema 'sometime during my shift'. You said in your written statement *"[Witness 5] had not instructed me to do an enema specifically as the patient was my patient but [Witness 5] was not directly supervising me during that shift. [Witness 5] had a good relationship with the patient. [Witness 5] attended the patient with me because he was acting strangely, and his cannula had come out. [Witness 5] asked if I had done an enema because she thought he was encephalopathic. I said that I had not done one yet, but I did an enema soon after this incident. There was no further discussion. As far as I am aware, there was no mention of this incident again or any concerns arising out of it".*

Witness 5 said in her NMC witness statement ***"****On the afternoon of 24 March 2021 I was busy with the patients I was allocated doing blood transfusions, but needed another IV stand, so went to the Nurse's allocated bay to borrow one. When I was in the bay I noticed that the patient in Bed 8 (Patient A), who I had previously cared for on the Ward, did not look like themselves, appearing drowsy and confused, which suggested to me that they may be encephalopathic. As I was busy, and Patient A was not one of my allocated patients for the shift, I found Ms Mutasa and asked them to check Patient A and give them an enema. I thought that they were going to do this, so went back to completing the blood transfusions for my patients. After I had stabilised my patients having blood transfusions, I went back to Ms Mutasa after around 30 minutes to an hour, and asked whether they had given an enema to Patient A. Ms Mutasa responded that they had not done the enema so I reminded them again and said that if they were not going to do it I would do it myself. I did not want to bypass Ms Mutasa as Patient A was their patient, but it was important that the enema was done so the patient did not deteriorate further. Ms Mutasa's response to me was "okay ma'am", in a sarcastic tone. Ultimately Ms Mutasa gave the enema after my second time reminding them, and once the enema was completed and Patient A was*

given a commode they stabilised and got better". This was consistent with your local statement and oral testimony.

The panel also had sight of the action plan which was handwritten, signed and dated 25 March 2021 by Witness 5 giving an account of this incident.

In your witness statement you are clear that you received the instruction to administer the enema in the morning handover. You have not disputed that your discussions with Witness 5 and the eventual administration of the enema took place in the afternoon. Having already found Witness 5 to be a credible and reliable witness, the panel accepted her detailed account of the incident and your attitude. In oral evidence Witness 5 explained that the patient was in danger of becoming encephalopathic, she explained to the panel that when saying this it meant that it was urgent *'It means that a nurse should do as much as possible to stop it happening'*. Witness 5 said that at the time she asked you to give the enema you did not tell her that you were busy with anything else, and she expected you to do it straight away, and to prioritise this task as the patient was *'appearing drowsy and confused'*. The panel considered that this was your patients, and you were responsible for them. It considered that if you were reluctant or if you were unsure or you needed assistance administering the enema it was your responsibility to ask someone for help or support.

The panel considered the meaning of delay and determined on the balance of probabilities, that you did delay the administration of an enema to the patient and it therefore found charge 11b proved.

Charge 12a

12. On 29 March 2021, in regards to an unknown patient, failed to:
    a. Ensure that a sliding scale was administered on an unknown patient.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's and Witness 6's evidence and your evidence.

Your evidence again is that you have no recollection of this incident. You said in your written statement *"I first learnt of this incident on 30/06/2021 when I received the end of probation report. I asked for evidence and specific information and received no response. I am unable to comment further".*

Witness 1 said in her NMC witness statement *"This was another incident reported by [Witness 6] that I was involved in. This occurred on 29 March 2021, when I was working with the Nurse as the Ward was short staffed, so I was assisting with supporting the Nurse. At the start of the shift, at around 08:30, I asked [Witness 6] to assist in setting up a sliding scale (VRIII) for one of the Nurse's patients, as I was busy with other tasks and the VRIII is an IV medication, and the Nurse was not signed off to administer IV's alone. A VRIII is a machine and pump used for administering insulin to diabetic patients, and is set up as a scale so the patient gets a certain amount of insulin every hour. [Witness 6] explained that they prepared the VRIII for the Nurse and went to the patients' bedside with the Nurse, at which time the patient asked if they could shower before it was started, which we agreed to. [Witness 6] reported that they asked the Nurse to let them know when the patient was ready for the VRIII to be started, but the Nurse never came back to them. The patient was going for an endoscopy that day, and at around 12:00 when the endoscopy staff came to the Ward to collect the patient I was surprised to find that the VRIII had not started. I asked the Nurse why this was and they said they thought [Witness 6] had started it again, although [Witness 6] reports that they told the Nurse they needed to let them know when the patient was ready".*

Witness 6 said in his NMC witness statement *"At the beginning of the shift, [Witness 1] asked me to help Ms Mutasa set up a sliding scale (VRIII) for one of Ms Mutasa's patients who was going for an endoscopy later in the day. A sliding scale is used to manage hyperglycaemia or hypoglycaemia (high or low blood sugar) for diabetic, insulin*

dependent, patients. Ms Mutasa's patient was diabetic, and as they were having an endoscopy were nil by mouth, so could not eat food. Not eating alters blood sugar, as a sliding scale is used to manage their blood sugar levels. I was asked to assist Ms Mutasa with this as the sliding scale is an IV medication, and I understood that Ms Mutasa was not allowed to administer IV medication themselves, although I do not know the details of why this was. After [Witness 1] asked me to assist, I prepared the sliding scale medication in the clinical room on the Ward and went with Ms Mutasa to the patient's bedside to administer it. When we arrived at around 08:30, the patient said they wanted to shower first, which we accepted. As I had other responsibilities on the shift I asked Ms Mutasa to let me know when the patient was ready, as I would then return to assist with administering the sliding scale. Later in the day, at around 12:00, the endoscopy staff came to collect the patient, at which time it was found that the sliding scale had not been started". Witness 6's evidence was consistent with his local statement and oral testimony.

The panel found Witness 1's and Witness 6's evidence to be consistent. Having already found both witnesses to be credible and reliable, the panel accepted their accounts of the events. They both described how it was important that the sliding scale was administered to the patient as they were nil by mouth prior to the endoscopy later that day so it was a procedure that was required to be done that morning. It was noticed at around 12pm that the sliding scale had not been administered to the patient when the endoscopy staff came to collect the patient. The panel considered that this was your patient, and you were responsible for them and therefore responsible for ensuring that the sliding scale was administered which you failed to do. Witness 6 specifically made sure that you knew it was your responsibility to call him when the patient was ready.

The panel determined that you had a duty to ensure that a sliding scale was administered, and you failed to do so. It therefore found charge 12a proved.

Charge 12b

> 12. On 29 March 2021, in regards to an unknown patient, failed to:

b. Escalate an unknown patient with a NEWS score over 7.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Witness 6 and your evidence.

Your evidence is that you have no recollection of this incident. You said in you written statement *"I first learnt of this incident on 30/06/2021 when I received the end of probation report. I asked for evidence and specific information and received no response. I am unable to comment further".*

Witness 6 said in his NMC statement *"On the same shift, on 29 March 2021, as Nurse in Charge I was conducting the usual Nurse in Charge overview of all patients on the Ward. When conducting this review, I found that one of Ms Mutasa's patients had a NEWS score of 7, and that Ms Mutasa had not escalated this to me, despite the patient having had that score for around an hour. I accept that the observations, to formulate the NEWS score, could have been completed by a HCA, however, as the registered nurse responsible for the patient Ms Mutasa should have at least been checking these regularly. A NEWS score above 5 is very serious, and can lead to an intensive care admission, so seeing a score of 7 was very concerning. I went to the patient myself and managed their deterioration, requesting that the HCAs on the Ward assisted with observing the patient and escalating any changes in their condition to me. I then found Ms Mutasa, who was walking towards the staff room for a break and asked if they were concerned about any of their patients. Asking this kind of explorative question was normal for me to ask before a nurse went on break so that I knew what was happening whilst the nurse was away from the Ward. Ms Mutasa responded that their patients were all fine, and when I asked again, denied that any of their patients were deteriorating. I then explained to Ms Mutasa that one of their patients had a NEWS score of 7, and they did not appear to know, giving me a blank stare".*

The panel found Witness 6's account of the incident to be detailed and consistent. He described his concern that you failed to take responsibility for your allocated patients, and that your failure to provide direct care for them, demonstrated a lack of understanding that patient safety is the priority.

Having already found Witness 6 to be credible and reliable, the panel accepted his account of the events. The panel considered that this was your patient, and you were responsible for them. The panel accepted that HCAs may have completed the observations but considered that it was your responsibility to review these and the resulting NEWS scores and escalate these where necessary. The panel also accepted Witness 6's proposition that, at the least, a nurse should review patients clinical status before leaving to have a break from duties. The panel determined you had a duty to escalate a patient with a NEWS score over 7 and you failed to do so. It therefore found charge 12b proved.

Charge 13

13. Between January 2021 to April 2021, you endeavoured to administer a nebuliser to an unknown patient without a prescription.

This charge is found proved.

The panel accepted the advice of the legal assessor that the word 'endeavour' is synonymous with 'attempted' and that the legal definition of 'an attempt' is an action that is more than merely preparatory.

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

Your evidence is that you have no recollection of this incident.

Witness 4 said in her NMC statement *"I was working a day shift with Ms Mutasa and supervising their medication round. I observed them getting the nebuliser machine for one of their patients, who I recall was having respiratory problems. A nebuliser is a device that converts medication into an inhalable mist, by using compressed air to produce droplets of liquid containing the drug, which is then inhaled by the patient through a mouthpiece or face mask. Nebulisers can help improve patient breathing, and have to be prescribed before they can be administered. I asked Ms Mutasa whether the nebuliser was prescribed for their patient, and they said they did not know. I therefore checked their patient's drug chart and found that the nebuliser was not prescribed, so stopped Ms Mutasa from giving it to their patient. Ms Mutasa felt their patient would benefit from the nebuliser, but I had to explain that they could not give it as it was not prescribed. I do not have access nor do I hold a copy of the patient's drug chart. I asked Ms Mutasa what they could do if they thought a patient would benefit from a specific medication, but they could not answer. I confirmed to Ms Mutasa that they could contact a doctor and ask if they could prescribe the nebuliser, as they would then be able to administer it. Ms Mutasa had been working on the Ward for some time at the time of this incident, and I recall thinking that they should have known to check if a medication is prescribed, and that they could not administer it if not prescribed. I note that in cases of emergency oxygen can be given without a prescription, however, in this incident the patient's oxygen saturation was not compromised, and in any event nebulisers can help breathing for some patients but are not used in emergency situations. The most common nebuliser is salbutamol which always needs a prescription".* This was consistent with Witness 4's oral testimony and local statements.

The panel also had sight of your action plan which was handwritten, signed and dated by Witness 4 on 16 February 2021 where this incident is recorded *"She forgot to check drug chart before giving nebulisers and they weren't prescribed".* The panel noted that the comments in the action plan also included some positive comments about your work that day and therefore appeared to be objective and balanced, albeit that the comments concluded with the statement *"she can't cope having patients on her own from my point of view".*

Having already found Witness 4 to be credible and reliable, the panel accepted her detailed account of the incident. The panel was satisfied on the balance of probabilities that you endeavoured to administer a nebuliser to an unknown patient without a prescription. It therefore found charge 13b proved.

Charge 14a

14. On 6 April 2021 you:
    a. Did not carry out observations on an unknown patient;

This charge is found proved.

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

Your evidence is that you have no recollection of this incident. You said during your oral evidence that you had just been in a meeting where you had been returned to supernumerary status and you were upset *"I was an observer that day [Witness 4] did everything that day, I was in a state, everything was a blur".*

The panel had sight of meeting notes from the 6 April 2021 which supported your evidence that you had been returned to supernumerary status. In the meeting with you, Witness 1 and Witness 4 it was stated *"The purpose of the meeting was to explain her she had to return to her Supernumerary period. This decision was made after receiving several reports from the Ward Nurses that have been completing Farayi's Action Plan, and considered her practice on the ward was unsafe for the patients".*

Witness 4 said in her local statement *"I went back to Farayi and told her that [an HCA] already told her about this issue and that she should have done her observations. She accused [the HCA] of been sitting down on the nurse's station instead of doing the*

observations for her patients. I told her that that was not right and is the nurse's responsibility to make sure patients have observations done and that we all should work as a team. I also explained her that if [the HCA] did not do the observations is because she had to cover the break for the other HCA doing 1:1 in bed 4. Due to Farayi been resilient to do her own observations, I asked the student […] who was very willing to help, and she did the observations for Farayi's patients".

Having already found Witness 4 to be credible and reliable, the panel preferred her detailed account of the incident. The panel did not accept your evidence that you being supernumerary meant that you were merely observing and not acting as a nurse that day. The panel was satisfied that supernumerary meant you were supervised not that you had no clinical tasks to complete. The panel has had sight of the meeting notes of 6 April 2021, and Witness 4's local statement in relation to the care you provided on that day. It has also heard and seen from Witness 1 and Witness 4 and was satisfied that there is no evidence that you were in fact 'in a blur' during that shift. It accepted that you were upset but nothing more. The panel also considered that if you were feeling unable to focus during your shift, you should have asked to go home.

The panel was satisfied on the balance of probabilities that you did not carry out observations on the patient. It therefore found charge 14a proved.

Charge 14b

14. On 6 April 2021 you:
    b. Did not monitor blood glucose on an unknown patient;

This charge is found proved.

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

Your evidence is that you have no recollection of this incident. You said during your oral evidence that you had just been in a meeting where you had been returned to supernumerary status and you were upset *"I was an observer that day [Witness 4] did everything that day, I was in a state, everything was a blur".*

The panel had sight of meeting notes from 6 April 2021 which supported your evidence that you had been returned to supernumerary status. The meeting with you, Witness 1 and Witness 4 stated *"The purpose of the meeting was to explain her she had to return to her Supernumerary period. This decision was made after receiving several reports from the Ward Nurses that have been completing Farayi's Action Plan, and considered her practice on the ward was unsafe for the patients".*

Witness 4 said in her local statement *"I asked Farayi to make sure the blood glucose for his only diabetic patient was done in the evening and when I checked with her again, one hour after, she told me she has not done it yet. It was 7pm already and the patient had had his diner. I found out later that it was our student again who ended up doing the blood glucose".* [sic]

Having already found Witness 4 to be credible and reliable, the panel preferred her detailed account of the incident. The panel did not accept your evidence that you being supernumerary meant that you were merely observing and not acting as a nurse that day. The panel was satisfied on the balance of probabilities that you did not monitor blood glucose of the patient. It therefore found charge 14b proved.

Charge 14c

14. On 6 April 2021 you:
    c. Did not complete fluid balance chart/s and/or bedside charts for patients assigned to your care.

This charge is found proved.

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

Your evidence is that you have no recollection of this incident. You said during your oral evidence that you had just been in a meeting where you had been returned to supernumerary status and you were upset *"I was an observer that day [Witness 4] did everything that day, I was in a state, everything was a blur".*

The panel had sight of meeting notes from the 6 April 2021 which supported your evidence that you had been returned to supernumerary status. The meeting with you, Witness 1 and Witness 4 stated *"The purpose of the meeting was to explain her she had to return to her Supernumerary period. This decision was made after receiving several reports from the Ward Nurses that have been completing Farayi's Action Plan, and considered her practice on the ward was unsafe for the patients".*

Witness 4 said in her local statement *"The one completing the fluid balance chart for Farayi's patients and the bedside folders was our student, instead of Farayi which needs to demonstrate her competence".*

Having already found Witness 4 to be credible and reliable, the panel preferred her detailed account of the incident. The panel did not accept your evidence that you being supernumerary meant that you were merely observing and not acting as a nurse that day. The panel was satisfied on the balance of probabilities you did not complete fluid balance chart/s and/or bedside charts for patients assigned to your care. It therefore found charge 14c proved.

Charge 15

15. Your action/s at charge 14a, 14b and/or 14c failed to prioritise tasks.

This charge is found not proved.

The panel considered the submissions made on your behalf that the NMC has not provided any evidence as to what tasks you chose to do instead of the tasks you should have done.

The panel accepted the submission made on your behalf in respect of this charge. It was of the view that it had not been given evidence of which tasks you should have prioritised or what you chose to do instead. The panel considered that it was clear that you were not providing adequate care to your patients but the evidence before it does not demonstrate a failure to prioritise tasks.

The panel therefore found charge 15 not proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether those facts it found proved amounted to a lack of competence 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 a lack of competence. Secondly, only if the facts found proved amount to a lack of competence, the panel must decide whether,

in all the circumstances, your fitness to practise is currently impaired as a result of that lack of competence.

Submissions on lack of competence

The NMC has defined a lack of competence as:

> *'A lack of knowledge, skill or judgment of such a nature that the registrant is unfit to practise safely and effectively in any field in which the registrant claims to be qualified or seeks to practise.'*

Ms Fitzgerald invited the panel to take the view that the facts found proved amount to a lack of competence.

Ms Fitzgerald further submitted that the conduct in these charges involve a serious departure from the NMC Professional standards of practice and behaviour for nurses, midwives and nursing associates ("the Code").

Ms Fitzgerald provided written submissions, and further oral submissions in relation to lack of competence, and impairment.

Ms Fitzgerald submitted that the charges found proved show that Ms Mutasa failed to demonstrate the standards of knowledge, skill and judgment required to practise without supervision as a Band 5 nurse and her fitness to practice is thereby impaired by reason of lack of competence.

Ms Fitzgerald submitted that in relation to Charges 1a, 1b, and 1c, these show a failure to prioritise people, specifically to make sure that any treatment, assistance or care for which you are responsible, is delivered without undue delay (1.4 the Code). In relation to the dirty pads on the floor, Ms Fitzgerald highlighted your failure to keep to and promote recommended practice in relation to *controlling and preventing infection* (19.3 the Code).

Further, it was submitted that your error in failing to complete the fluid balance chart was a failure to comply with part 10 of the Code and *keep clear and accurate records*. You failed to escalate urine retention which also shows a failure to *make a timely referral to another practitioner when any action, care or treatment is required* (13.2 the Code).

It was submitted that these failings led to a patient requiring urgent catheterisation which may not have been required if the fact they were retaining urine had been identified by you earlier in the shift. This was considered particularly concerning by Witness 1, as you had only one patient to care for on this shift.

In relation to Charge 2c, Ms Fitzgerald submitted that this charge shows a failing to comply with part 1.4 of the Code: *to ensure treatment and care was provided to patients they are responsible for is delivered without undue delay* and part 13.3 of the Code: *to preserve patient's safety, particularly the requirement to ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond your competence*. She further referenced section (8.5 of the Code) and highlighted that you failed to show an ability *to work with colleagues to preserve the safety of those receiving care* (8.5 the Code). Ms Fitzgerald submitted that there was a risk of bleeding if the patient was not given the additional bag of FFP, as heard in Witness 3's evidence.

Ms Fitzgerald submitted in relation to Charges 3a, and 3b, that these show a *failing to prioritise people* (1 of the Code), particularly the requirement to *'make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay'* (1.4 of the Code) and to *preserve patient safety* (13 of the Code). They also show an inability to *work with colleagues to preserve the safety of those receiving care* (8.5 of the Code).

Ms Fitzgerald highlighted Witness 3's evidence, which made clear that there was also a risk that if the patient had continued to be ignored and no one else attended, they may have tried to move themselves which could have resulted in a fall.

Ms Fitzgerald submitted that in relation to Charge 4, this charge encapsulates the same reasonings as those stated above in Charges 2c, 3a and 3b.

Ms Fitzgerald submitted that in relation to Charges 5a, 5b and 5c, these charges show a failure to *practise effectively* (6 to 8 of the Code); *accurately identify*, *observe and assess signs of normal or worsening physical and mental health in the person receiving care* (13.1 of the Code); *make a timely referral to another practitioner when any action, care or treatment is required* (13.2 of the Code); and to *raise and if necessary escalate any concerns you may have about patient or public safety* (16.1 of the Code).

Ms Fitzgerald further referenced Witness 1's statement, whereby it was stated that the failure to complete observations as soon as the patients were transferred created a risk of serious harm to patients.

In relation to Charges 11a and 11b, Ms Fitzgerald submitted that these charges show an inability to *prioritise people*. She further stated that they show an inability to *work with colleagues to preserve the safety of those receiving care* (8.5 of the Code); to *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay* (1.4 of the Code) and to *preserve patient's safety particularly to accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care* (13.1 of the Code).

Ms Fitzgerald referenced Witness 1's evidence, where it was stated that there was risk involved as the patient could have fallen from the commode or got a pressure sore. Moreover, it showed a lack of respect for the patient.

In relation to Charges 12a and 12b, Ms Fitzgerald submitted that these charges show a failure to *ask for help from a suitably qualified and experience professional to carry out any action or procedure that is beyond your competence* (13.3 of the Code); a failure to *make a timely referral to another practitioner when any action, care or treatment is required*

(13.2 of the Code) and an inability to *work with colleagues to preserve the safety of those receiving care* (8.5 of the Code).

Ms Fitzgerald referenced the evidence of Witness 1, where it was stated that the failure to administer medication in a timely manner to this patient could have caused delay in patient procedures, and in the cancellation of the procedure, which could then have repercussions for the patient. It also meant that the medical team had to wait for the patient to have the procedure when they could have been completing other work.

In relation to Charge 13, Ms Fitzgerald submitted that this charge was a breach of part 18 of the Code, particularly, 18.2, which imposes a duty on a nurse to keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs. The charge also shows a failure to comply with The Medicines Management Policy that only medications which have been prescribed by a doctor should be administered.

Ms Fitzgerald highlighted the evidence of Witness 4, who had stated that this concern was serious as there is a risk in giving a patient the wrong medication, and in the worst case this could cause serious harm or be fatal if they were allergic to the medication.

Finally, in relation to Charges 14a, 14b, and 14c, Ms Fitzgerald submitted that these charges show a failure to *practise effectively* (part 6 to 8 of the Code); ac*curately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care* (13.1 of the Code) and the failure to *complete fluid balance charts or bedside charts* fell short of part 10 and the requirement to *keep clear and accurate records*. It was submitted that although you returned to supernumerary status on this shift, you still had tasks that you were responsible for. However, you did not carry out observations as you were required to do, which is a clear indication of a lack of competence. Ms Fitzgerald submitted that you did not do the bare minimum required from a registered nurse, being that of observing patients and completing relevant and required records.

Ms Fitzgerald referenced the evidence of Witness 1, who had stated that these failings were serious because not doing observations as required or at all risks missing patients' deteriorating and therefore not knowing if escalation is needed. There is therefore a risk to patient safety.

Mr Santos-Costa made both written and oral submissions on lack of competence and impairment.

Mr Santos-Costa submitted that the NMC's starting position for a registered nurse, as outlined in the NMC guidance, is that they are usually a safe and competent professional, but something may have happened that got in the way of you delivering safe care. Mr Santos-Costa submitted that it is appropriate to assess your competence generally, together with the circumstances at the material time, before considering whether the conduct contained within the facts found proved is so serious to warrant a finding that you have demonstrated a lack of competence.

Mr Santos-Costa submitted that you were deprived of the opportunity to learn and develop from the action plans and was inadequately supported by the Trust throughout your probation period. He submitted that the support offered was nugatory and it failed to address the issues that were affecting your performance at work. Mr Santos-Costa further submitted that the Trust failed to resolve the isolation and seclusion that you experienced while working in the Ward, and that there was no evidence of proper effort made to fully investigate your concerns of institutional bullying.

Mr Santos-Costa, in relation to Charge 1a, submitted that the NMC have failed to provide any information whatsoever about the nature of the patients' needs to support this charge. He submitted that as a result, the panel is not able to properly assess whether your failure to offer to wash the patient, or to carry out personal care, is serious or not. Mr Santos-Costa submitted that without that crucial information, the panel cannot ascertain whether the patient required a wash, or whether the patient was independent and self-sufficient. Mr

Santos-Costa submitted that in relation to this charge, there is not enough evidence to find that you have demonstrated lack of competence.

Mr Santos-Costa, in relation to Charge 2c, submitted that you were not competent to perform intravenous medication. In line with the Blood Transfusion Policy, he submitted that you were not competent to perform any part of the blood transfusion process. He submitted that your conduct in this regard would not constitute an *'unacceptably low standard of work',* or be considered a serious lack of competence, in the circumstances. Mr Santos-Costa submitted that in relation to Charge 3a, Witness 3 had expressed that it was the responsibility of everyone to respond to the call bell. Witness 3 further stated that she believed you to be the closest nurse to the patient using the bell, however accepted that the patient was not calling out for you specifically.

Mr Santos-Costa, in relation to Charge 3b, submitted that you had prioritised the drug round over making a patient's bed, and that in these circumstances, this would not be considered a serious lack of competence.

Finally, Mr Santos-Costa, in relation to Charge 11a, submitted that your failure to respond to the call bell on this occasion also, should not be considered ''serious'' or an ''unacceptably low standard of work'', as it was not purely your responsibility, but is shared amongst all members of the nursing staff.

Mr Santos-Costa concluded that in regard to Charge 3a, 3b, and 11a, there is no demonstration of an ''unacceptably low standard of work'', and therefore no evidence of lack of competence.

Mr Santos-Costa, in relation to Charges 5a, 5b and 5c, submitted that the panel should consider the wider clinical context when assessing these charges. He submitted that Howard Ward had transformed into a COVID-19 Ward midway during the shift. Mr Santos-Costa referenced the evidence given by Witness 6, where he had stated that this was a very stressful time for everyone, and he preferred to carry out observations himself

because it was quicker. Mr Santos-Costa submitted that you had had only been practising as a registered nurse post-supernumerary for a matter of days. He therefore submitted that, as a result of these external factors and the circumstances, these charges do not indicate that you have demonstrated a lack of competence.

Mr Santos-Costa, in relation to Charge 11b, submitted that the panel must not speculate as to what you did or did not do in this period of time, as there is no evidence that you were aware that a procedure was required urgently. Further, it was submitted that a delay of this procedure or its administration for an unjustifiable reason, would demonstrate a lack of competence; however, this is not what you did. Mr Santos-Costa submitted that when one looks at this incident objectively on the evidence before the panel, it is clear that this is an isolated incident and that this conduct does not demonstrate an "unacceptably low standard of work", and it is not demonstrative of a "serious" lack of competence.

Mr Santos-Costa, in relation to Charge 13, submitted that this conduct is not indicative of a lack of competence, and is an isolated incident which was not intentional, or repeated. He reminded the panel of the NMC guidance which recognises that a nurse may make a mistake, and that this charge relates to an isolated incident. He submitted that this charge does not demonstrate an "unacceptably low standard of work" and is not so serious as to warrant a finding of lack of competence.

Mr Santos-Costa, in relation to Charges 14a, 14b, and 14c, submitted that although these charges are found proved, it does not follow that your failure to undertake these tasks indicates a lack of competency. Mr Santos-Costa submitted that once returning to your supernumerary status on 6 April 2021, your role was to merely observe during the remainder of the shift, and that you did not *'count'* as a nurse. As a result, Mr Santos-Costa submitted that this conduct would not amount to a lack of competence when your actions are judged against what was reasonably expected of you during that shift.

Mr Santos-Costa highlighted that a registered nurse, as outlined in the NMC guidance, is usually a safe and competent professional, but something may have happened that got in

the way of delivering safe care. This lack of competence must be serious, and you must demonstrate a low standard of work, which you did not. He further noted that the following factors which had impacted your general practice:

1) *Your feelings of isolation and being bullied in the workplace and the fact that you often felt uncomfortable and tearful on shift. You often felt you were 'tiptoeing' around colleagues due to their attitudes.*
2) *The external pressures and stressors attributed to working as a very newly qualified nurse during the peak of the COVID-19 pandemic.*
3) *The absence of other colleagues, especially on 3 January 2021.*
4) *The lack of adequate support in relation to strengthening your practice.*
5) *The impact of Howard Ward on your performance.*
6) *Your status and lack of experience as a newly qualified nurse.*

Mr Santos-Costa therefore submitted that you do not have attitudinal or judgemental issues, and therefore, in the circumstances, and specifically considering the factors identified above, the panel ought to find that you have not demonstrated an unacceptably low standard of work or a serious lack of competence.

Submissions on impairment

Ms Fitzgerald 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.

Ms Fitzgerald submitted that your fitness to practise is impaired on the grounds of protection of the public and the wider public interest. She submitted that the charges found proved are indicative of your lack of competence and impaired practice. It was submitted that your failings were serious and led to patients being at risk. Ms Fitzgerald submitted that in a number of charges, you were prompted to do something and, either failed to do

so, or could not do so within the time expected. She submitted that you were provided with *‘intense’* supervision and guidance yet were still unable to show competence in a range of areas.

Ms Fitzgerald submitted that you were on your probation period throughout the time of these charges; however, you were given a probationary review in February 2021, where issues were raised. Your probation was then extended, giving you the opportunity to comply and to present competence, yet, throughout this time, you still showed a lack of competence.

Ms Fitzgerald submitted that Witness 1 and Witness 4, in their live evidence, made clear that you were given the help you needed to improve your practice, but your lack of competence persisted. Further, Witness 1 and Witness 4 also gave live evidence regarding the mediation that was offered and the attempts to help Ms Mutasa with the issues she appeared to be having with some members of staff.

Ms Fitzgerald submitted that you have denied any fault except for one admission, namely Charge 11a. She submitted that this demonstrates a lack of insight and therefore a risk of repetition. Ms Fitzgerald submitted that there has also been nothing advanced to show that you have taken steps to remediate the lack of competence.

Therefore, Ms Fitzgerald submitted that there is no reduction in risk and thus that fitness to practise is impaired on both public protection and public interest grounds.

Mr Santos-Costa submitted that the factual findings do not lead to a finding of impairment.

Mr Santos-Costa submitted that the context in which things have happened must be considered, particularly two specific areas. Firstly, he submitted that your personal factors relating to the professional working environment and culture, and the way in which these may have adversely affected your ability to practise safely and professionally, must be

considered. Secondly, the panel should take into consideration the fact that the supervision provided to you was not fair and adequate.

Mr Santos-Costa referenced the training certificates provided and highlighted that you have been working as a healthcare assistant and a live-in carer during the period of September 2021 through to May 2023. Mr Santos-Costa also provided the panel with a four character references.

Mr Santos-Costa submitted that your fitness to practise is not currently impaired.

Decision and reasons on lack of competence

The panel took account of all of the evidence in this case and the submissions of Ms Fitzgerald and Mr Santos-Costa. It accepted the advice of the legal assessor which included references to the principles in a number of relevant judgements.

When determining whether the facts found proved amount to a lack of competence, the panel took into consideration the contextual factors of this case.

The panel took note of the fact that at the time these events occurred, you were a staff nurse on your probation and were very new to your role. The panel considered the fact that, whilst you had the same title and job description as another qualified Band 5 registered nurse, your role was different from that of your colleagues. Further, the panel considered the fact that you were supernumerary during some of the period when the events happened.

The panel took note that you were working on a specialised ward, and you may have required more time than your more qualified and experienced colleagues. However, the panel considered that you would have been required to focus on your allocated patients, and not been expected to complete wider, more extensive duties.

The panel further took into consideration that you began this role and were working during the Covid-19 Pandemic outbreak. It noted that you were working during a challenging time. It considered that this pandemic was particularly pertinent in respect of the context of Charges 5a, 5b, and 5c.

The panel considered that the charges found proved involved a significant number of events which occurred over just 22 shifts, resulting in a number of wide-ranging failings identified by a range of different qualified nurses who worked with you.

The panel acknowledged that you were assigned mentors and did have a Practice Development Nurse allocated to you during your time at the Todd and Dawson Ward. The panel considered that the witnesses that were working with you and in supervisory roles were more vigilant, concerned, and not confident that they could leave you to practise alone without close supervision.

The panel acknowledged that there was no preceptorship or a designated lead mentor for you. It further considered the fact that it has not seen any evidence that the action plans were discussed with you, or that they were used as a supportive development tool.

The panel noted from the evidence that you were aware of the action plans and took part in the meeting in which they were agreed on 15 February 2021. The panel however also noted that you received no feedback for such action plans.

The panel was of the view that it was a supportive move to have transferred you to Todd and Dawson Ward from Howard Ward; this enabled you to be better supported and in a more controlled and comfortable environment. The panel acknowledged that at this stage you felt vulnerable, and that the moving of Wards would have been beneficial to your development as a registered nurse. However, the panel did note your concerns raised through an email on 4 January 2021, in which you claimed the Ward environment involved *'negativity'*.

The panel referenced the email which was sent on 5 February from you to Witness 1, in which you referred to *'bullying'* several times. The panel also noted the meeting notes from 17 March 2021, where bullying was once again raised.

[PRIVATE]

The panel determined that, although you had raised the issue of the toxic work environment, and there being institutionalised bullying, you were not prepared to name who was involved. The extent of the investigation, therefore, was that staff members were spoken to individually, and it was concluded that the Ward did not appear to be toxic, nor was there institutionalised bullying.

The panel took into consideration the action plans set in place to improve your practice. The panel determined that there appears to be some lack of clarity regarding the meeting on 15 February 2021. It considered the fact that you were told you must improve communication, reflection, and prioritising tasks, but on the other hand, the probation review note stated that you had worked well with patients, relatives, and other members of the Ward. The panel however determined that the action plan was formulated and discussed with you in a meeting later in the day on 15 February. Therefore, the panel concluded that you should have understood what was required of you.

[PRIVATE]

When determining whether the facts found proved amounted to a lack of competence, the panel also had regard to the terms of the Code. In particular, the following standards:

[Professional standards of practice and behaviour for nurses, midwives and nursing associates: The Code, 2018.]

As a registered nurse, 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.

1.5) Respect and uphold people's human rights.

8.5) Work with colleagues to preserve the safety of those receiving care.

13.1) Accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care.

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.

20.1) Keep to and uphold the standards and values set out in the Code.

The panel bore in mind, when reaching its decision, that you should be judged by the standards of the reasonable Band 5 registered nurse in the circumstances in which you were working and not by any higher or more demanding standard.

The panel determined that the following charges reach the threshold of an unacceptably low standard of performance and are serious. It was of the view that the charges which are not mentioned below, but were found proved, did not amount to a lack of competence.

These charges were matters where what was proved, was that you did not do something, rather than that you failed to do it, and were matters to which other individuals could, and did, attend.

The panel determined that in relation to Charges 1b and 1c, these charges are serious and amount to a lack of competence. The panel noted that these events caused discomfort to a patient and further posed a risk of harm. The panel highlighted that due to your actions which were identified by your colleague, the patient required urgent catheterisation, which evidences that the patient was under a real risk of harm. The panel determined that it was also significant that you were only looking after one patient on this day yet failed to follow a basic sequence of care, expected from a registered nurse.

The panel determined that in relation to Charge 2c, it acknowledges that you were not able to administer the required medication as you had not been trained. However, the panel noted that in accordance with its findings, you were responsible to make sure the medication was administered; you would have had sight of the prescription chart. The panel determined it was your primary responsibility and that your actions could have resulted in serious harm, and a risk of serious bleeding if the patient had gone into the procedure without the prescribed dosage of FFP. Therefore, this charge falls well below the standard of what one would expect from a registered nurse and amounts to lack of competence.

The panel determined that in relation to Charge 4, this is serious and falls below the standard of what one would expect from a registered nurse, resulting in a lack of competence. The panel highlighted your failure as a nurse to be organised, focused, and diligent in ensuring that your patient had received the prescribed dosage of FFP that they required. The panel noted the relevance of its rationale in Charge 2c, to Charge 4.

The panel determined that in relation to Charges 5a, 5b and 5c, the conducting of observations and assessments of patients and their conditions is a fundamental aspect of nursing practice. The panel took into account that new patients with COVID-19 had been

admitted to the Ward, and that you did not have a handover. It was therefore crucial, taking into account your patients' known respiratory condition, to conduct observations, which you did not do. Consequently, the panel concluded that your actions fell below the standards expected from a registered nurse, and result in a lack of competence.

The panel determined that in relation to 11b, your delaying of the administration of the enema for a patient is serious as it shows an inability to prioritise patients. Further, the panel noted that you were informed that the administration of the enema was required at the handover stage for this patient, first thing in the morning. However, the patient did not receive the enema until the afternoon, which was after your colleague had prompted you at least twice. On the first occasion, your colleague had made it clear to you that your patient was encephalopathic. The panel concluded that this charge did result in actual patient harm as the patient became drowsy and confused. In the panel's judgement, this charge does present a lack of competence.

The panel determined that in relation to charge 12a, it is aware that you were not trained to administer a sliding scale yourself, but nevertheless, you were responsible to ensure this was administered to the patient, which you did not do. The panel determined that this charge presents a lack of competence.

The panel determined that in relation to Charge 12b, this is extremely serious as it was your responsibility to escalate the fact that the patient had a NEWS score over 7. This caused a real risk of very serious harm. The panel noted that if it were not for the intervention of the nurse in charge, then real and severe harm could have been caused. The panel further noted that Witness 6 highlighted that the crisis team were contacted as a result of your lack of competence.

The panel determined that in relation to Charge 13, this is serious and falls far below the standard of skill expected of any trained nurse, regardless of their experience. The panel regards it as a fundamental requirement that nurses check prescriptions before endeavouring to administer any medication. Further, it noted that this event could have

resulted in a real risk of patient harm, had your colleague not intervened, and stopped you. The panel further noted that you were not aware of what you needed to do in the situation you had faced in this charge. This charge results in a lack of competence.

The panel determined that in relation to Charges 14a, 14b and 14c, these are serious and amount to a lack of competence for the same reasons stated in charges 5a, 5b, and 5c above. The panel noted that any of these three errors could have led to serious harm. The panel considered the effect of the change in your status to supernumerary nurse earlier that day, but you were still responsible for undertaking specific delegated tasks and the skills required were basic procedures, which you did not carry out.

The panel considered and highlighted the following three quotes from witness evidence:

Witness 1, on 29 February 2021, commented in her action plan, stating *'tasks such as basic nursing care, medications, reports weren't getting done'.*

Witness 4, on 1 April 2021, recorded in her notes in her local statement *'anytime I have to work with her, I am coming stressed to the shift thinking I have to do my nurse in charge duties and supervise every patient she is being asked to look after'.*

Witness 5, on 2 April 2021 stated in her email to Witness 1,*'I feel unsafe to work with her especially when the ward has high acuity'*.

Witness 5, on 1 August 2022, in her witness statement, stated *'I was having to assist Ms Mutasa to such a high level, I was essentially having to look after their patients as well. I genuinely felt like I could not trust Ms Mutasa looking after their patients alone'.*

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that your practice was significantly below the standard that one would expect of a registered nurse acting in your role, and unacceptably so.

In all the circumstances, the panel determined that your performance demonstrated a lack of competence.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

> *'In determining whether a practitioner's fitness to practise is impaired […] 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 […] show that his/her/their fitness to practise is impaired in the sense that S/He/They:

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

The panel found that patients were put at risk, with some experiencing actual harm as a result of your lack of competence. Your lack of competence brought the profession in to disrepute. The panel determined further that your inability to complete basic nursing tasks is a cause for concern, and although you have received training and supervision, you still present a lack of competence.

Regarding insight, the panel considered that, with the exception of one course, there is no evidence of learning or development in regard to the charges found proved against you. The panel determined that the concerns in this case can be addressed, but have not been, and therefore, the concerns are highly likely to be repeated.

In its consideration of whether you have taken steps to strengthen your practice, the panel took into account your annual confirmation of mandatory training. The panel concluded that this does not provide it with reassurance that you would be practising any more safely now, than when the incident initially occurred. It noted that, while you have been practising as a carer and as a HCA since these events, and have positive testimonials about your

performance in those capacities, you have not practised as a registered nurse and have not had the responsibilities of one. Further, the panel has not received any evidence of self-awareness and reflections from you, regarding the impact of your actions on your patients and colleagues.

The panel is of the view that there is a risk of repetition based on your lack of acknowledgement and lack of insight, and the absence of any strengthening of your practise, alongside a real risk of harm. 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 are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding proper professional standards for members of those professions.

The panel determined that, in this case, a finding of impairment on public interest grounds was required. A well-informed member of the public would expect a registered nurse to be able to efficiently care for patients in a safe, kind, and adequate manner.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. As a result of this order, your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

Submissions on sanction

Ms Fitzgerald submitted that the NMC sanction bid is a 36-month conditions of practice order. She submitted that this order is most appropriate as it would keep patients safe, given the concerns which led to the charges found proved. Ms Fitzgerald further submitted that a conditions of practice order is the necessary and proportionate sanction as there are areas in which your practice is in need of re-training; giving you the opportunity to continue practising provides you with the ability to improve. Ms Fitzgerald submitted that patients will not be placed in any danger through a conditions of practice order, and that conditions can be both formulated and assessed.

With regard to aggravating factors, Ms Fitzgerald submitted the following:

- *There were a number of incidents found proved, which occurred in a short space of time.*
- *You have presented a lack of insight and not provided any level of adequate reflection.*

With regard to mitigating factors, Ms Fitzgerald submitted the following:

- *You raised allegations that you felt bullied in the workplace.*
- *The COVID-19 pandemic resulted in an intense working environment.*
- *You were a newly qualified nurse and were in your probationary period.*
- *You have been working as a carer during the interim period.*

Mr Santos-Costa submitted that, whilst the NMC have stated that your lack of insight is an aggravating feature, he reminded the panel that you as a registrant should not be judged for defending yourself. He stated that you are entitled to defend the allegations made against you both robustly and fairly. Mr Santos-Costa highlighted that you have not been able to provide insight or reflection to the panel as you have not been able to recollect the incidents mentioned within the charges. He submitted that, in order for lack of insight to amount as an aggravating feature, there must be more evidence presented.

Mr Santos-Costa also provided submissions on the mitigating features in your case. He highlighted that there is evidence that you have followed good practice, which is shown through the training you have undertaken. He further noted the positive character references which were presented before the panel, stating that these serve as evidence that you have worked well as a health care worker.

Mr Santos-Costa submitted that you have a staunch desire to continue practising as a nurse and that you have demonstrated this by continuing to remain in the caring field during the interim period.

Further, [PRIVATE] It was emphasised that you were a newly qualified nurse in January 2021 whilst NHS hospitals were overwhelmed by the COVID-19 pandemic. Further, it was highlighted that you were in your probationary period and had only been practising for a number of months and were therefore, still in the process of learning what your role entailed. Mr Santos-Costa reminded the panel that you felt bullied whilst on the ward, that you felt you were working within a toxic environment and had not completed all of your training. Therefore, Mr Santos-Costa submitted that when the panel considers the public interest, the proper atmosphere of a working environment should also be considered.

Mr Santos-Costa submitted that a caution order would serve to mark the concerns in this case, without going any further. He submitted that this order would enable you to continue working as a registered nurse whilst also developing your practice. Mr Santos-Costa submitted that the public would be disappointed to understand the difficulties you had experienced and would be sympathetic towards you.

Mr Santos-Costa submitted that, if the panel is not minded to agree with him on the request for a caution order, you would be willing to comply with a conditions of practice order. However, he stressed that the NMC’s application for a 36-month conditions of practice order is both inappropriate and disproportionate. Mr Santos-Costa submitted that

a 36-month period of this order would cause you great difficulty in being able to find suitable work.

Mr Santos-Costa submitted that, if the panel does consider that the more appropriate order is a conditions of practice order, it should only be implemented for a period of 12 months. He submitted that this would be a period which would provide effective support for you whilst practising, and that any longer than this should be regarded as punishment.

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 Sanctions Guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

In reaching its decision, the panel took account of all the evidence, including the testimonials and other material provided by you, and the submissions of counsel. It accepted the advice of the legal assessor concerning its powers and the approach it should take to sanction.

The panel took into account the following aggravating features:

- *Your lack of understanding of how your errors may have impacted both patients and your colleagues.*
- *You have not presented any reflection and learning regarding the incidents which the panel have found proven.*
- *There were numerous incidents which were highlighted by a variety of supervisors, which demonstrated that you failed to be competent on a number of different occasions.*

- *There were numerous incidents which occurred in a relatively short period of time, over a relatively small number of shifts that you worked before being dismissed by your employer.*

The panel also took into account the following mitigating features:

- *The period in which these events occurred was a difficult and challenging time for you due to the impact of the COVID-19 pandemic, the fact that you were a newly qualified nurse, the fact that you felt bullied by colleagues on the Ward.*
- *You felt that you were overwhelmed by your environment and had a lack of support from your employer as a first-time nurse.*
- *The positive character references you provided describing your practice, from a range of roles which included your previous HCA roles, and in particular, from an relative of an individual whom you lived with and cared for. This reference described you as having been professional and reassuring.*
- *Your desire to learn, improve, and continue as a registered nurse.*

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the need to protect the public. The panel decided that it would be neither proportionate nor in the public interest to take no 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 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 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, in particular the following, which are applicable in this case:

- *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;*
- *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 practicable conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with conditions of practice.

The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to practise as a nurse.

Balancing all of these factors, the panel determined 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 or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case because you have not presented any deep-seated attitudinal concerns or caused great harm to any patient or colleague.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will meet the need to maintain public confidence in the profession and will declare to the public and the profession the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case, and will be adequate to protect the public:

'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 which must not be an agency.*

2. *Until you are deemed to be, and signed off as, competent in medicines management by a registered nurse at your place of work, you must be directly supervised when administering medication, by a registered nurse.*

3. *You must ensure that you are supervised by a line manager, or other supervisor nominated by your employer, 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, a registered nurse who is neither on probation nor preceptorship.

4. You must have weekly meetings with your supervisor, to discuss the topics below. After the first 8 weeks with any new employer, this may be changed to monthly meetings if your supervisor deems it appropriate based on your performance. These meetings should consist of a review of the following:

Your activities addressing patient care, including:

- *Personal care*
- *Observations of patients*
- *Escalations of concerns about patients in your care*
- *Planning and prioritising your responsibilities, and*
- *Medicines management.*

5. a) You must keep a reflection record to cover the following subjects:

Your activities addressing patient care, including:

- *Personal care*
- *Observations of patients*
- *Escalations of concerns about patients in your care*
- *Planning and prioritising your responsibilities, and*
- *Medicines management.*

b) You must have a monthly supervision meeting with your line manager or other supervisor nominated by your employer.

c) The above reflection record must be completed in preparation for this monthly supervision meeting. This must be signed by your supervisor each time to confirm that it has been discussed and that

they agree that it is a fair reflection of your performance; or to add comments regarding your performance, if different.

d) You must send copies of all monthly reflection record to your case officer at 6 months and at 10 months after these conditions come into effect.

6. *You must keep us 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 us informed about anywhere you are studying by:*
   a) *Telling your case officer within seven days of accepting any course of study.*
   b) *Giving your case officer the name and contact details of the organisation offering that course of study.*

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) Any 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 order is for a period of 12 months. The panel is satisfied that this is the appropriate and proportionate period in the circumstances of your case.

Before the order expires, a panel will hold a hearing to review the order and to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may vary any condition of it, it may replace the order with another order, and it may extend the order or make a different order.

Any future panel reviewing this case would be assisted by:

- Your continued engagement and your attendance at any future hearing;
- Testimonials from any paid or unpaid work, including your current employer at the time this order is reviewed;
- Evidence of any ongoing training you are undertaking;
- A final reflective piece addressing the shortcomings identified in your case, and their impact on your patients and others and on what you have learned since.

This will be confirmed to you in writing.

Submissions on interim order

The panel took account of the submissions made by Ms Fitzgerald. She submitted that the NMC are seeking an interim conditions of practice order for a period of 18 months.

Mr Santos-Costa did not make any submissions in relation to an interim order.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that the only suitable interim order would be that of an interim conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be for a period of 18 months in order to allow for the time that it may take for an appeal to be heard, and that this is proportionate in the circumstances.

The panel has taken into account the impact this order will have on you but has concluded that the public interest outweigh this. It is satisfied that an order is proportionate.

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 you have been sent the decision of this hearing in writing.

That concludes this determination.