Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday, 10 – Friday, 12 December 2025

Virtual Meeting

Name of Registrant:	Silpa Vijayan
NMC PIN	23K1486O
Part(s) of the register:	Registered Nurse – Adult Nursing RNA – (20 November 2023)
Relevant Location:	Dorset
Type of case:	Lack of competence
Panel members:	Michelle Lee (Chair, Registrant member) Rashmika Shah (Registrant member) Norah Christie (Lay member)
Legal Assessor:	Graeme Dalgleish
Hearings Coordinator:	Nicola Nicolaou
Facts proved:	Charges 1a, 1b(i), 1b(ii), 1b(iii), 2a(i), 2a(ii), 3a, 3b, 3c, 3d, 3e, 4a, 4b, 4f, 5a, 5b(i), 5b(ii), 5c(ii), 6 (excluding 15 January 2024), and 7
Facts not proved:	Charges 4c, 4d, 4e, 5c(i), and 5d
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mrs Vijayan's registered email address by secure email on 5 November 2025.

The panel accepted the advice of the legal assessor.

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

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

Details of charge

That you, a registered nurse, failed to demonstrate the standards of knowledge, skills and judgment required to practice as a Band 4 and/or 5 nurse without supervision in that you:

1. Failed to appropriately manoeuvre and transfer patients, in that you:

    a. On 17 August 2023 you inappropriately moved Patient A onto a commode without the brakes applied which had then caused Patient A to fall.

    b. On 22 March 2024 you inappropriately mobilised Patient B, in that you:

        i. looked to mobilise Patient B by yourself.
        ii. When Colleague A attended to assist, you abandoned Patient B causing them to then put all their weight on Colleague A,
        iii. You actions in charge 1)b)ii) caused Colleague A to sustain an injury.

2. On 18 November 2023:

    a. Whilst attempting to take a blood pressure reading for Patient C:

        i. Failed to activate the sphygmomanometer in order to take the necessary blood pressure reading.
        ii. Recorded the previous patient's blood pressure reading

3. On 1 April 2024:

    a. Failed to encourage patients to mobilise in order to use the toilet and instead encouraged them to use their incontinence pads.

    b. Failed to prepare adequate patient notes and/or documentation, in that you failed to provide sufficient detail in respect of the patients' conditions.

    c. On one or more occasions you failed to correctly admit patients onto the ward.

    d. Refused to leave Patient D, despite having been asked to do by both Patient D and Colleague B.

    e. Failed to lock the medication trolley.

4. On 8 April 2024:

    a. Despite being supernumerary, collected a patient from theatre alone.

    b. Failed to correctly respond to a Patient E who was found unresponsive on a commode.

    c. Attempted to administer 20mls of Oramorph (40mg) instead of the prescribed 10mg.

d. Failed to understand and/or note down what had been discussed during the morning handover.

e. Failed to respond to requests for the administration of pain relief from the patients.

f. Attempted to administer Heparin to a patient using an incorrect needle

5. On 15 April 2024:

a. Inappropriately communicated with dementia patients in that you used condescending and/or patronising phrases to include:

- ‘Well done’
- ‘Good girl’

b. In relation to Patient F:

i. Poked them in the ribs on the site of an injury, causing unnecessary pain.
ii. Failed to gain their consent before pulling back the bedsheets to start administering treatment.

c. In respect of Patient G, used inappropriate language and behaviour in trying to administer Patient G’s insulin in that you:

i. Waved the insulin injection in front of Patient G’s face
ii. Shouted the phrase “I give, I give”

d. In respect of Patient H, you administered pain relief medication 2.5 hours late, meaning they could not undergo their scheduled physiotherapy.

6. Failed medication assessments on the dates as detailed in Schedule 1.

7. In respect of Patient I, who is diabetic, you failed to appropriately manage and/or treat their high blood sugar.

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

Schedule 1

- 28/11/2023
- 23/12/2023
- 24/12/2023
- 15/01/2024
- 08/03/2024
- 12/04/2024
- 15/04/2024

Background

Mrs Vijayan was referred to the Nursing and Midwifery Council (NMC) on 16 April 2024 by an anonymous referrer.

The referral identified the following regulatory concerns:

1. Lack of competence - in that Mrs Vijayan has failed to demonstrate the standards of knowledge, skills and judgment required to practise without supervision as a Band 4 Nurse in the following areas:
    i. moving and handling of patients
    ii. managing a workload
    iii. communication
2. Poor medication assessment and administration
3. Failure in recognising and escalating deteriorating patients.

These regulatory concerns relate to incidents that are said to have taken place at Dorset County Hospital ('the Hospital') between around June 2023 and April 2024. During this time, Mrs Vijayan was employed by the Hospital on the Trauma and Orthopaedics Ward ('the Ward'), first as an international nurse, then as a Band 4 nurse, following her registration with the NMC in November 2023.

It is alleged that Mrs Vijayan was provided with additional support and training, including support from Human Resources (HR) and the Head of Education, and the implementation of a development plan on 23 August 2023. This development plan was allegedly reviewed regularly, and a performance review was held on 14 March 2024, but Mrs Vijayan is said not to have met her competencies within the probationary period and was dismissed from her role on 26 April 2024.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all of the documentary evidence in this case provided by the NMC and Mrs Vijayan.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Colleague A: Deputy Sister on the Ward at the time of the alleged incidents.
- Colleague B: Registered Nurse on the Ward at the time of the alleged incidents.
- Witness 3: Ward Sister at the Hospital at the time of the alleged incidents.

- Witness 4: Deputy Sister on the Ward at the time of the alleged incidents.

- Witness 5: Registered Nurse on the Ward at the time of the alleged incidents.

The panel also had regard to written representations from Mrs Vijayan and her responses to the Trust's Probationary review meeting dated 26 April 2024. The panel noted that Mrs Vijayan has provided some explanations but she has not responded, in any detail, to the allegations. She has not unequivocally denied or admitted any of the charges.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by both the NMC and Mrs Vijayan.

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

Charge 1a

> That you, a registered nurse, failed to demonstrate the standards of knowledge, skills and judgment required to practice as a Band 4 and/or 5 nurse without supervision in that you:
>
> 1. Failed to appropriately manoeuvre and transfer patients, in that you:
>
>   a. On 17 August 2023 you inappropriately moved Patient A onto a commode without the brakes applied which had then caused Patient A to fall.

This charge is found proved.

Firstly, the panel noted that the stem of the charges states *'That you, a registered nurse* […]*'*. However, the panel noted that charge 1a refers to an allegation that occurred on 17 August 2023, although you did not join the NMC register until 20 November 2023. The

panel noted that you were employed by Dorset County Hospital NHS Foundation Trust ('the Trust') as a registered Band 4 nurse on 14 July 2023. The panel considered that you were a registered nurse in India, before moving to the United Kingdom (UK) on an international nurse sponsorship.

In reaching this decision, the panel took into account Witness 3's witness statement which stated:

> *'After doing the mandatory manual handling training, an incident occurred on 17 August 2023 where Silpa moved a patient onto a commode and took the brakes off. Silpa had not put the patient on the commode properly, this had caused them to fall.* […] *When I spoke to Silpa, it was clear she was also upset as she claimed she did not know how to put the brakes on from having never used a commode before* […] *Silpa had extra training on the ward on 31 August 2023 and undertook a repeat training session on moving and handling on 5 September.'*

This is supported by Witness 4's witness statement which stated:

> *'There was an incident with Silpa failing to place a patient appropriately on a commode, which had resulted in the patient falling off the commode.* […]*'*

This is further supported by Colleague A's witness statement which stated:

> *'There was an instance where Silpa had put a lady on a commode and caused her to fall as she failed to put the brakes on. Silpa did not apologise for the incident or take accountability for her actions, but rather, said that no one had told her that there were brakes. Silpa had the relevant training (including the moving and handling training) and knew the commode had brakes as she saw other nurses use them.* […]*'*

The panel noted that three different witnesses provided consistent evidence in relation to this incident. The panel considered that although Mrs Vijayan had stated that she had not used the commode before, she had completed moving and handling training as part of her induction with the Trust, and also received additional support and training from the Trust.

Therefore, Mrs Vijayan should have either known how to use a commode, or asked a colleague to show her before attempting to use it. By not doing so, Mrs Vijayan failed to demonstrate the standards of knowledge, skills, and judgement required to practice as a Band 4 nurse. The panel considered that Mrs Vijayan had a duty as a registered nurse to manoeuvre and transfer patients safely. The panel therefore found this charge proved on the balance of probabilities.

Charges 1b(i), 1b(ii), and 1b(iii)

1. Failed to appropriately manoeuvre and transfer patients, in that you:

    b. On 22 March 2024 you inappropriately mobilised Patient B, in that you:

        i. looked to mobilise Patient B by yourself.
        ii. When Colleague A attended to assist, you abandoned Patient B causing them to then put all their weight on Colleague A,
        iii. You actions in charge 1)b)ii) caused Colleague A to sustain an injury.

These charges are found proved.

In reaching this decision, the panel took into account Colleague A's witness statement which stated:

> *'During my shift on 22 March 2024, a male patient was in a cubicle and Silpa had gone in to assist him as he needed the toilet. She then proceeded to stand him up from his chair. It should have been obvious to Silpa that he was not weightbearing well on his legs and arms as he was a weak man. On the handover, it was documented that the patient was able to mobilise with a Zimmer frame and had been to the toilet. Silpa should have known to risk assess the patient when she stood him up. Following her trying to get him to stand, Silpa should have sat the patient back down and asked for help. However, she instead got the patient up and 10 steps from the chair* […] *As she was struggling, she shouted to me for help.* […] *Silpa and I were supporting him on either side. I asked Silpa why she did this, to which she kept repeating that the patient "needed the toilet". I told Silpa that she*

should have got the patient on the commode. Due to the language barrier, Silpa thought this meant to go and get the commode. Silpa then completely let go of the patient, causing all his weight to fall onto me, which I did not expect. This resulted in me sustaining a strain type of injury to my neck and shoulder.'

This is supported by an email from Colleague A to Witness 3 dated 22 March 2024 which stated:

'I wanted to email and document concerns about Silpa today. She called out to me from cubicle 5 and had mobilised the patient […] *by herself with a Zimmer to the toilet outside the room. When I looked over it was clear to see that the patient was unable to mobilise. He was not putting weight through his legs or one of his arms and Silpa was struggling to hold him up.* […] *I went over and helped her to steady him. I asked her why she had mobilised him when he was so unsteady* […] *she just kept repeating that he needed the toilet. I said to her that when he stood and it was clear he could not walk she should have got a commode rather than mobilise him to the toilet. I believe that at this point she thought I wanted her to go and get a commode and she just let go of the patient which meant I then very suddenly had his entire body weight pill down on my shoulder injuring my arm and neck.* […]'

The panel took into account Mrs Vijayan's response to the regulatory concerns which stated:

'I did not do mistakes purposefully,I have no any personal intention to hurt or injure my colleague.Always I tried to do moving and handling with the use of right equipment as per the handoversheet.As per the incident they reported ,I called for help to support my patient from fall.but the staff whohelped me spoke rudely to me in front of patient and reported the manager wrongly [sic]'

The panel considered that there was a misunderstanding between Mrs Vijayan and her colleagues, as well as communication difficulties. The panel noted that Colleague A was a direct witness and found her to be clear and consistent in her account of the incident.

The panel noted that although it was documented that the patient was able to mobilise with a Zimmer frame, Mrs Vijayan should have known to risk assess the patient. Therefore, she failed in her duty to demonstrate the standards of knowledge, skill, and judgement required to practice as a registered nurse. The panel therefore determined that these charges are found proved on the balance of probabilities.

Charges 2a(i), and 2a(ii)

2. On 18 November 2023:

    a. Whilst attempting to take a blood pressure reading for Patient C:

        i. Failed to activate the sphygmomanometer in order to take the necessary blood pressure reading.
        ii. Recorded the previous patient's blood pressure reading

These charges are found proved.

In reaching this decision, the panel took into account Colleague A's witness statement which stated:

> *'There was concern over how Silpa could put the BP readings in if she had not blown up the cuff, and the patient thought she had used the other patient's BP readings. I checked this and saw that Silpa had put the exact same BP readings for both male patients who were next to each other in the same bay, only a few minutes apart. I explained to Silpa what she had done and asked her questions to see if she understood what she had done wrong. Silpa then responded by saying the patient was wrong, however I could not see how he could be. I showed Silpa the numbers and explained the likeliness of this event, however she carried on maintaining her stance that they were different. I then explained to Silpa that she would not be in trouble if she had incorrectly read the blood pressure, but that we needed to know,* […] *Silpa then backtracked and said she perhaps did make a mistake. I explained to Silpa the dangerous nature of this incident,* […] *I also reminded her of the importance of duty of candour. As the patient was post-*

operative his blood pressure readings were very important. I told Silpa her actions could result in the patient being at risk of harm. […]*'*

This is supported by an email from Colleague A to Witness 3 dated 18 November 2023 which stated:

'[…] *when Silpa did his BP she put on the cuff but did not press the button and take a reading and that he was sure that the numbers she put in were from the patient in the next bed. I have checked this on the vital pac and it is correct. Silpa did enter the exact same BP result for both patients 4 minutes apart.* […] *Finally when I told her she was not in trouble but that I wanted her to be more careful she conceded that she may have made the mistake.'*

The panel considered that Mrs Vijayan appeared to be inconsistent in her acceptance and denial of this incident. The panel noted that Mrs Vijayan maintained for a long time that she took the blood pressure reading correctly, but later admitted to repeating the previous patient's reading instead. The panel considered that Mrs Vijayan should have known about the importance of monitoring blood pressure for post-operative patients. By recording the previous patient's blood pressure reading, Mrs Vijayan failed in her duty to conduct patient observations accurately and correctly. That duty arises from the Code and the panel therefore found these charges proved on the balance of probabilities.

Charge 3a

3. On 1 April 2024:

    a. Failed to encourage patients to mobilise in order to use the toilet and instead encouraged them to use their incontinence pads.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement which stated:

‘Silpa would frequently fail to get patients out of bed to use the toilet and would instead encourage them to use their pad. The patients on the ward are encouraged to use the toilet rather than pads as its part of their rehabilitation. […] *Silpa should not have been encouraging continent patients to use their pads’*

The panel also took into account Colleague B’s email to Witness 3 and Witness 4 dated 1 April 2024 which stated:

‘- telling patients to use pads for toileting instead of assisting them to the toilet or using a bed pan’

The panel considered that Colleague B is the only witness who gives evidence in relation to this charge. The panel found that Colleague B’s evidence was clear and consistent in their recollection of this incident. The panel considered that as a Band 5 registered nurse, Colleague B would have been observing Mrs Vijayan on a daily basis. The panel decided that Mrs Vijayan had a duty to encourage patients to mobilise and use the toilet, rather than use their incontinence pads, given the NMC Code. The panel therefore found this charge proved on the balance of probabilities.

Charge 3b

3. On 1 April 2024:

    b. Failed to prepare adequate patient notes and/or documentation, in that you failed to provide sufficient detail in respect of the patients’ conditions.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B’s witness statement which stated:

‘Silpa did not include enough detail in her patient notes, as they remained short and sweet. Her notes would state ‘patient stayed in bed, patient ok, no real concerns’, and they would lack any medical detail.’

The panel also took into account an email from Colleague B to Witness 3 and Witness 4 dated 1 April 2024 which stated:

'- not writing in enough detail in patients notes'

The panel noted that concerns had been raised regarding Mrs Vijayan's communication, in particularly, her note taking. The panel found that Mrs Vijayan had a basic duty as a registered nurse to prepare adequate patient notes and documentation, given the NMC Code. The panel considered that Colleague B was fair and balanced in her feedback regarding Mrs Vijayan. It found Colleague B to be clear and consistent across her witness statement and her contemporaneous email. The panel therefore found this charge proved on the balance of probabilities.

Charge 3c

3. On 1 April 2024:

    c. On one or more occasions you failed to correctly admit patients onto the ward.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement which stated:

'There were ongoing concerns that Silpa failed to admit patients onto the ward correctly. […] *I regularly went through this process with Silpa. Silpa would fill in the front page on why the patient was admitted and their past medical history, however she would then skip the contact details, forget to check the patient's skin check, and would write in the nursing notes that the patient had arrived on the ward, rather than having detailed notes.'*

The panel found that Mrs Vijayan had a duty as a registered nurse to correctly admit patients onto the ward, given the NMC Code. It found Colleague B to be clear and consistent in her witness statement. The panel found this charge proved on the balance of probabilities.

Charge 3d

3. On 1 April 2024:

    d. Refused to leave Patient D, despite having been asked to do by both Patient D and Colleague B.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement which stated:

> *'An incident occurred where Silpa refused to leave a patient, despite the patient asking her to do so. The patient was a 30-year-old woman who had been admitted. The patient wished to be left alone whilst she washed and changed. I explained to Silpa that the patient was independent and was able to carry out these self-care tasks independently. I went over this a number of times with Silpa for a long time and told her to leave the patient. Silpa refused and said she understood what I was saying, but wanted to wait until I went first. The patient did not like the fact that Silpa did not seem to understand or car about her or her wishes.* […] *I asked Silpa to go on a break and I told her I would come to find her, as I was trying to find ways to get Silpa to leave. When I left the bedside, I came back to see Silpa still stood with the patient watching them wash themselves. When Silpa finally left the bedside, I took her to one side and asked why she did not leave when I asked her to. Her response was to laugh, and she turned round and said "I'm going on break" or words to that effect.'*

The panel also took into account Witness 3's timeline of events which stated:

‘1/4/24 Another situation which arose where a pt specifically asked Silpa to leaver [sic] *her alone to have a wash (pt was independent), she would not leaver* [sic] *her and watched her have a wash. Pt said she felt very uncomfortable then shouted for me and asked me to take Silpa away from the bed space. Silpa refused and would not come after asking several times. After explaining when Silpa just laughed.’*

The panel considered that Colleague B was clear and consistent in their witness statement regarding this incident. The panel noted that patients have a right to privacy, and that Patient D was made to feel uncomfortable as a result of Mrs Vijayan’s actions. The panel found this charge proved on the balance of probabilities.

Charge 3e

3. On 1 April 2024:

    e. Failed to lock the medication trolley.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B’s witness statement which stated:

‘Silpa did not correctly lock medication away in the trolley. She finished the drug round and left the trolley open. If nurses go to another room or move elsewhere, they must lock the medication trolley as it has a lot of strong medication in. This places patients at risk as any patients would be able to access these medications and taken them without any observation. This was particularly risky for dementia patients as they would not understand what the medication was and mistake them for sweets and take them. […]*’*

The panel also took into account an email from Colleague B to Witness 3 dated 1 April 2024 which stated:

‘- not locking drugs trolley just walking off leaving it open’

The panel also took into account the letter from the meeting dated 26 April 2024 which stated:

> *'*[…] *you were advised that you still needed to be reminded to assist patients with medications and not leave them on the trolleys.* […] *You said that you would not leave the medication cupboard unlocked or leave the medication trolley unattended* […]*'*

The panel gave considerable weight to the letter from the meeting dated 26 April 2024 which was sent to Mrs Vijayan. It is clear, cogent, and consistent with the evidence, and is broadly contemporaneous. The panel considered the witnesses to be clear and consistent in their documentary evidence. By not locking the medication trolley, Mrs Vijayan's actions put patients at risk of harm. The duty to do so is clear within the NMC Code. The panel found this charge proved on the balance of probabilities.

Charge 4a

4. On 8 April 2024:

    a. Despite being supernumerary, collected a patient from theatre alone.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement which stated:

> *'*[…] *I saw Silpa wheeling a patient into the ward from theatre alone. Although Silpa had her NMC PIN at this stage, she was still supernumerary so a registered nurse should have gone with her to escort the patient from theatre. Silpa's supernumerary capacity meant she must work together with the registered nurse. in relation to transferring a patient from theatre or the recovery ward, the nurse should check whether the patient is stable and ready for transfer. A patient is only brought back to the ward if the registered nurse is happy with their condition, and if not, the patient*

would stay in the recovery ward until they were stable. Silpa had left the ward, accepted the patient, did not tell the nurse in the recovery ward that she was supernumerary, and wheeled the patient back to the ward. […] *Silpa should have waited for me so we could both go to collect the patient together. We had collected patients together before and I had previously stressed the importance that she could not go alone as she was still supernumerary.* […] *Every supernumerary nurse is accompanied by a non-supernumerary nurse, and this varies upon experience. I had previously told Silpa that whilst she was still supernumerary, she could not collect patient from theatre alone. She seemed to understand this and on previous occasions she had waited for me.'*

The panel also took into account an email from Colleague B to Witness 3 and Witness 4 dated 8 April 2024 which stated:

'The two major and most concerning/ dangerous issues I had was the fact that Silpa went to recovery to collect a patient by her self. She took handover and I found her wheeling the patient out of recovery on her own. I had specifically said at least twice that she was not to collect the patient from recovery on her own and was to come and find me when she had finished her task on the ward and we had to go together. […] *She had not told the recovery staff she was still super-nummery* [sic] *and couldn't make the decision to bring the patient back to the ward. After speaking to her she couldn't tell me the risks with the situation and why she should not collect patients on her own. She also couldn't tell me anything about the surgery or post op plan other than the patient was 'ok''*

The panel noted that Colleague B provided a lot of detail as to why a supernumerary nurse should not have collected a patient from theatre alone. The panel considered Colleague B to be clear and consistent in her documentary evidence. By collecting the patient from theatre alone when you were told not to, and not being able to demonstrate your understanding of the risks, you did not demonstrate the required knowledge and skills of a registered nurse. The panel found this charge proved on the balance of probabilities.

Charge 4b

4. On 8 April 2024:

    b. Failed to correctly respond to a Patient E who was found unresponsive on a commode.

This charge is found proved.

In reaching this decision, the panel took into account Colleague B's witness statement which stated:

> *'Another incident occurred where Silpa found a deteriorating patient unresponsive on a commode. This had occurred in the morning near the beginning of a shift. Silpa correctly pulled the crash bell; however, she did not know what to do next and stood in the corner. Silpa did not place an oxygen mask on the patient, and she did not understand what was going on or why. The doctor asked Silpa what had happened; however, she could not say.'*

The panel noted that this was supported by Witness 3 and Witness 4, who both recalled a similar account of the incident in their witness statements.

The panel also took into account Witness 3's timeline of events which stated:

> *'The second problem/ issue was regarding a deteriorating patient. Silpa had found a patient unresponsive on the commode and had pulled the crash bell, which is positive. However she didn't understand what to do next. She didn't put any oxygen on the pt or get an observations. I also turns out that she didn't understand what happened either* […]'

The panel also took into account the letter from the meeting dated 26 April 2024 which stated:

> *'You said that you did not leave the patient and pulled the bell and when the other staff arrived you went to get the oxygen.* […] *You added that it* [sic] *you find an unresponsive patient you would pull the call bell, take observations and give*

oxygen. You said that you know you need to improve but lack confidence and were nervous, which is why you think you have not improved. You said you felt you now knew what you needed to do and were disappointed by some of the negative feedback.'

The panel also had sight of the NMC Test of Competency Part 2 Objective Structured Clinical Examination (OSCE) which has a section outlining 'In Hospital Resuscitation, Deteriorating Patients, and Basic Life Support'.

The panel noted that three different witnesses speak consistently to this incident. It noted from the evidence that Mrs Vijayan passed her OSCE in October 2023 and received basic life support training. The panel considered that having completed the appropriate training, Mrs Vijayan had a duty as a registered nurse to respond effectively in emergency situations. The panel therefore found this charge proved on the balance of probabilities.

Charge 4c

4. On 8 April 2024:

    c. Attempted to administer 20mls of Oramorph (40mg) instead of the prescribed 10mg.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's timeline of events which stated:

'- wanting to administer 20ml of oramorph as getting confused with mg and ml'

The panel considered that there was no evidence before it of a prescription or a Medication Administrative Record (MAR) chart to prove that 10mg of Oramorph was prescribed. The panel considered that the NMC has not discharged its burden of proof to find this charge proved. The panel therefore did not find this charge proved on the balance of probabilities.

Charge 4d

4. On 8 April 2024:

    d. Failed to understand and/or note down what had been discussed during the morning handover.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 5's witness statement which stated:

> *'Many of my concerns are based around Silpa's communication as she struggled to communicate with both patients and doctors. I have included instances of these concerns which arose during the shift on 8 March 2024.'*

The panel also took into account an email from Witness 5 to Witness 3 dated 8 March 2024 which stated:

> *'Silpa seems to have issues with communication in multiple situations, at handover she is clearly not understanding all that is said,* […] *Silpa was required to hand over the patients she had heard handover for 30 minutes prior, she was unable to recall information that was not printed on the handover. I asked her where her extra notes were from the handover, she responded with 'no notes'.'*

The panel took into account that Witness 5's witness statement and email both refer to 8 March 2024, rather than 8 April 2024, as alleged in the charge. The panel therefore could not find this charge proved on the balance of probabilities. The panel did not consider that it was fair to amend the charge at this stage, particularly given that this meeting is being held in the absence of Mrs Vijayan.

Charge 4e

4. On 8 April 2024:

    e. Failed to respond to requests for the administration of pain relief from the patients.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 5's witness statement which stated:

> *'Many of my concerns are based around Silpa's communication as she struggled to communicate with both patients and doctors. I have included instances of these concerns which arose during the shift on 8 March 2024.'*

The panel took into account that Witness 5's witness statement refers to 8 March 2024, rather than 8 April 2024, as alleged in the charge. The panel therefore could not find this charge proved on the balance of probabilities. The panel did not consider that it was fair to amend the charge at this stage, particularly given that this meeting is being held in the absence of Mrs Vijayan.

Charge 4f

4. On 8 April 2024:

    f. Attempted to administer Heparin to a patient using an incorrect needle

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's witness statement which stated:

> *'There had been another concern on 8 April when Silpa had tried to use the wrong needle when administering Heparin to a patient.* […] *Silpa had to get this drug from*

the treatment room and draw it up into the syringe. Silpa had done so correctly and safely by using the correct blunt needle. However, to administer this drug, the needle must then be swapped to a smaller, much sharper needle as it was not necessary to have a large needle, as the needle did not need to go into a vein. Silpa had swapped the blunt needle out for another larger needle, normally used for putting something into a vein, rather than using the fine needle required.'

The panel also took into account Witness 3's timeline of events which stated:

'[…] *Another drug of concern was a dose of heparin, after I said this needed drawing up in treatment room for safety she then brought it out to bay to begin opening, after using a blunt needle to draw up, the was going to connect a large gauge needle to administer I said no this is subcutaneous, she then reattached the blunt needle and moved to the patient to give. I had to stop her and asked her to go and get a more appropriate needle.* [sic]*'*

The panel also took into account the letter from the meeting dated 26 April 2024 which stated:

'I explained that another drug of concern was a dose of heparin. You had been advised that this medication needed to be drawn up in the treatment room for safety but you had brought it out to the bay to begin opening, used a blunt needle to draw up and was going to connect a large gauge needle to administer, at which point you were told that a subcutaneous was needed. You then reattached the blunt needle and moved towards the patient to give before being stopped and asked to get a more appropriate needle. You said that you thought what you picked up was a subcutaneous needle and that both the large gauge needles and subcutaneous needles were in the same tray of the trolley. […]*'*

The panel found Witness 3 and Witness 5 to be credible witnesses who were clear and consistent in their account of this event. The panel therefore found this charge proved on the balance of probabilities.

Charge 5a

5. On 15 April 2024:

    a. Inappropriately communicated with dementia patients in that you used condescending and/or patronising phrases to include:

        - ‘Well done’
        - ‘Good girl’

This charge is found proved.

In reaching this decision, the panel took into account Colleague B’s witness statement which stated:

> *‘Silpa did not have the ability to adjust her communication skills to different patients and their differing needs. She failed to interact well with dementia patients,* […] *Silpa often came across as patronising with patients with cognitive impairments, as she would respond with ‘Well done’ or ‘Good girl, have a sweetie’ to patients taking tablets.’*

The panel also took into account an email from Colleague B to Witness 3 and Witness 4 dated 15 April 2024 which stated:

> *‘She asked me what is dementia and did not seem to comprehend what I said. She asked several questions but did not listen to what I said.’*

The panel found that Mrs Vijayan did not have a clear understanding of what dementia was, and therefore, it is likely that she communicated inappropriately with dementia patients and used condescending and/or patronising phrases included those alleged and referred to by the witnesses. The panel therefore found this charge proved on the balance of probabilities.

Charges 5b(i), and 5b(ii)

5. On 15 April 2024:

b. In relation to Patient F:

i. Poked them in the ribs on the site of an injury, causing unnecessary pain.
ii. Failed to gain their consent before pulling back the bedsheets to start administering treatment.

These charges are found proved.

In reaching this decision, the panel took into account Witness 5's witness statement which stated:

> *'The patient's rib fractures were being treated with lidocaine patches to help manage his pain. The lidocaine patch needed to be changed and Silpa went to do this whilst the patient was asleep.* […] *she pulled the cover back and poked the patient's ribs.'*

The panel also took into account the letter from the meeting dated 26 April 2024 which stated:

> *'We also discussed the patient who needed a lidocaine patch and it had been reported that you, without explanation, pulled back the bedsheet and started pushing at the old patch (an area of significant pain for the patient) before your colleaguing* [sic] *had to pull the sheet from you to cover the patient and apologise.* […] *You said that you needed to see the patch to understand and you did not pull the sheet off as described.'*

The panel also took into account an email from Witness 5 to Witness 3 dated 15 April 2024 which stated:

> *'*[…] *She then without comment pulled back the bedsheet and started pushing at the old patch (an area of significant pain for the patient). I had to pull the sheet from*

her, cover the young man and apologise. I firmly highlighted to Silpa the need for privacy and dignity, that she had not got consent, she had not closed the curtains and she had not yet greeted or woken him […]*'*

The panel considered that Witness 5 gave a detailed and cogent account of this incident. The panel noted that Mrs Vijayan appeared to have denied pulling back the bedsheet *'as described'*, as evidenced within the letter from the meeting dated 26 April 2024. However, the panel considered that Mrs Vijayan had a duty as a registered nurse to ensure the dignity and privacy of the patient, and gain their consent. Witness 5's evidence makes clear that consent was not sought or obtained from the patient. The panel preferred Witness 5's clear account of this incident and therefore found this charge proved on the balance of probabilities.

Charge 5c(i)

5. On 15 April 2024:

c. In respect of Patient G, used inappropriate language and behaviour in trying to administer Patient G's insulin in that you:

i. Waved the insulin injection in front of Patient G's face

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 3's witness statement which stated:

'Silpa was shouting to the patient 'I give, I give' and was shoving and waving the insulin in front of the patient's face.'

The panel also took into account the letter from the meeting dated 26 April 2024 which stated:

'You said that the patient was always like that and you did show her the pen, you hadn't meant for it to come across in that way.'

The panel noted that Witness 5 was the only direct witness to this incident, however, she did not mention the alleged incident of Mrs Vijayan *'waving'* the insulin injection in front of Patient G's face. The panel noted that Witness 3 broadly mentions this alleged incident in her witness statement, and that it is also mentioned in the letter from the meeting dated 26 April 2024. However, the panel considered that as Witness 5 was the only direct witness to this incident, she did not mention any 'waving of the insulin injection' as charged. The panel did not find this charge proved on the balance of probabilities.

Charge 5c(ii)

5. On 15 April 2024:

c. In respect of Patient G, used inappropriate language and behaviour in trying to administer Patient G's insulin in that you:

ii. Shouted the phrase "I give, I give"

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's witness statement which stated:

'Silpa had been asked to attend this patient to administer the insulin. Due to Silpa's poor communication skills and poor English, the patient became confused; […] *Silpa's response to the patient's confusion was to intrude his personal space whilst holding the insulin injection pen and loudly shout to him "I give, I give".'*

The panel also took into account Witness 3's witness statement which stated:

'Silpa was shouting to the patient 'I give, I give' […]*'*

The panel noted that Witness 5 was a direct witness to this incident and therefore found her account of this incident credible and reliable. The panel found that Mrs Vijayan did not communicate clearly, effectively, or appropriately and as a result, caused the patient some distress. The panel therefore found this charge proved on the balance of probabilities.

Charge 5d

5. On 15 April 2024:

d. In respect of Patient H, you administered pain relief medication 2.5 hours late, meaning they could not undergo their scheduled physiotherapy.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 5's witness statement which stated:

'There had been an occasion on 15 April where Silpa administered medication to a patient 2 and a half hours late.'

The panel considered that there was no evidence before it of a prescription or a MAR chart to indicate when the pain relief medication was due to be administered. The panel considered that the NMC has not discharged its burden of proof to find this charge proved. The panel therefore did not find this charge proved on the balance of probabilities.

Charge 6

6. Failed medication assessments on the dates as detailed in Schedule 1.

This charge is found proved (excluding 15 January 2024).

In reaching this decision, the panel took into account Witness 3's witness statement which stated:

‘Silpa continued to have medication assessments in April 2024, however, she was still making mistakes. Silpa failed to check the current prescription charts, nor did she check the allergy or dosage section on the JACS system.’

The panel also took into account Colleague A’s witness statement which stated:

‘She also numerous undertook drug assessments by various members of staff and never passed [sic]*’*

The panel had sight of the various medication assessments that Mrs Vijayan conducted on the dates set out in schedule 1. The panel noted that Mrs Vijayan appears to have failed the medication assessments on all of the dates, apart from on 15 January 2024 which it is recorded that she passed.

The panel therefore found this charge proved in relation to all of the dates set out in schedule 1, excluding 15 January 2024.

Charge 7

7. In respect of Patient I, who is diabetic, you failed to appropriately manage and/or treat their high blood sugar.

This charge is found proved.

In reaching this decision, the panel took into account Witness 4’s witness statement which stated:

‘Another incident occurred where Silpa was on a shift with a bank nurse dealing with a patient with high blood sugar. […] *When this happens, normal practice is to test ketones and tell the doctor and give a stacked dose of insulin to treat this. Silpa did the blood sugars; however it was not until the nurse on the blood round came to check that she noticed the patient’s blood sugar was high. Silpa did not make any note of this apart from on the insulin charts. This is normally done by the HCA*

(Healthcare Assistant), *so it is expected that a registered nurse should be able to give treatment without needing to be promoted. As a registered nurse, Silpa would be expected to escalate this patient's blood sugar and give prompt treatment herself, especially given that she had been working on the ward since July 2023, and had received extra diabetes training.'*

The panel considered that there was no evidence before it to contradict Witness 4's evidence. It considered Witness 4 to be clear and consistent in her account of this incident. The panel noted that Mrs Vijayan had been working on the Ward since July 2023 and had received additional training from the Trust. The panel considered that Mrs Vijayan had a duty as a registered nurse to appropriately manage and treat a patient with high blood sugar. Management and treatment of a condition are the fundamentals of safe and effective nursing care. The panel therefore found this charge proved on the balance of probabilities.

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 amount to a lack of competence and, if so, whether Mrs Vijayan's 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, Mrs Vijayan's fitness to practise is currently impaired as a result of that lack of competence.

Representations on lack of competence and impairment

The NMC has provided an undated Statement of Case which sets out its position in relation to lack of competence, impairment, sanction, and interim order. This will be summarised accordingly.

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 practice.'*

The NMC invited the panel to take the view that the facts found proved amount to a lack of competence. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ('the Code') in making its decision.

The NMC identified the specific, relevant standards where Mrs Vijayan's actions amounted to a lack of competence. A lack of competence needs to be assessed using a three-stage process:

- Is there evidence that Mrs Vijayan was made aware of the issues around her competence?
- Is there evidence that she was given the opportunity to improve?
- Is there evidence of further assessment?

The NMC invited the panel to find that the facts found proved show that Mrs Vijayan's competence at the time was below the standard expected of a Band 4 and/or Band 5 registered nurse. The NMC submitted that Mrs Vijayan does not have the knowledge, skills, and judgement required to practice safely as a nurse. Within the Statement of Case, the NMC submitted that:

> *'Whilst not every breach will amount to a lack of competence, it is submitted that this lack of competence is particularly serious because it wide ranging and this type of behaviour has been conducted throughout a significant period. Further, it is*

submitted that there has been no improvement in Mrs Vijayan's behaviour despite training being undertaken and supervision being provided to Mrs Vijayan.'

Mrs Vijayan did not provide any written submissions in relation to lack of competence.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The Statement of Case outlines that Mrs Vijayan acted in a manner which put patients, and her colleagues, at unwarranted risk of harm. The NMC further submitted that Mrs Vijayan's lack of competence breached fundamental tenets of the nursing profession and brought it into disrepute and called into question her professionalism.

The Statement of Case goes on to mention that Mrs Vijayan has not provided any evidence of insight or remediation, or confirmation that she has attended any training courses in order to demonstrate that she has strengthened her practice in the areas of concern which gave rise to these allegations. Despite being offered numerous methods of support and guidance throughout the course of her employment at the Trust Mrs Vijayan failed to make progress. Mrs Vijayan was said to have been shown the correct and safe way to undertake her duties but continued to make the same mistakes. The NMC therefore submitted that there remains a future risk of repetition and consequent risk of harm.

Regarding public interest, the Statement of Case states:

'It is submitted that Mrs Vijayan continues to present a risk to members of the public as such there is a need to uphold proper professional standards and public confidence in the profession. It is submitted that a finding of impairment is needed to uphold proper professional standards and conduct and / or to maintain public confidence in the profession.'

The NMC invited the panel to find Mrs Vijayan's fitness to practise impaired on the grounds of public protection and public interest.

Mrs Vijayan did not provide any written representations in relation to lack of competence or impairment.

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

Decision and reasons on lack of competence

When determining whether the facts found proved amount to a lack of competence, the panel had regard to the terms of the Code. In particular, it found that Mrs Vijayan had breached the following standards:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.1** treat people with kindness, respect and compassion*
> ***1.2** make sure you deliver the fundamentals of care effectively*
> ***1.3** avoid making assumptions and recognise diversity and individual choice*
> ***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*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> ***2.1** work in partnership with people to make sure you deliver care effectively*
> ***2.2** recognise and respect the contribution that people can make to their own health and wellbeing*
> ***2.3** encourage and empower people to share decisions about their treatment and care*
> ***2.4** respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care*

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

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

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1 *respect a person's right to privacy in all aspects of their care*

5.2 *make sure that people are informed about how and why information is used and shared by those who will be providing care*

7 Communicate clearly

To achieve this, you must:

7.1 *use terms that people in your care, colleagues and the public can understand*

7.2 *take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs*

7.3 *use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs*

7.4 *check people's understanding from time to time to keep misunderstanding or mistakes to a minimum*

7.5 *be able to communicate clearly and effectively in English*

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

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

10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
10.4 *attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*

13 Recognise and work within the limits of your competence
To achieve this, you must, as appropriate:
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*
13.4 *take account of your own personal safety as well as the safety of people in your care*
13.5 *complete the necessary training before carrying out a new role*

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.1 *keep to and uphold the standards and values set out in the Code*
20.3 *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
20.5 *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*
20.8 *act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to*

20.10 *use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times'*

The panel bore in mind, when reaching its decision, that Mrs Vijayan should be judged by the standards of a Band 4 registered nurse and not by any higher or more demanding standard. The panel considered that there were a wide range of serious breaches of the code across multiple areas of Mrs Vijayan's clinical practice and competencies. Mrs Vijayan also failed multiple medication assessments.

Taking into account the reasons given by the panel for the findings of the facts, the panel has concluded that Mrs Vijayan's practice was below the standard that one would expect of a registered nurse acting in Mrs Vijayan's role.

In all the circumstances, the panel determined that Mrs Vijayan's 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, Mrs Vijayan's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, 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. 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 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:

> '[…] *the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/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*
>
> c. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d. *…'*

The panel finds that patients and colleagues were put at risk of harm, and Colleague A in particular was caused actual physical harm as result of Mrs Vijayan's lack of competence.

Mrs Vijayan's lack of competence had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel took into account Mrs Vijayan's claim that she did not receive support from the Trust. However, the panel has had sight of extensive training, support, and development plans that were implemented to support Mrs Vijayan. The panel considered that Mrs Vijjayan demonstrates limited insight into her failures. The panel noted that Mrs Vijayan stated that she would do better, but that she did not explain how she would do this. The panel also noted that Mrs Vijayan did not identify her learning needs.

The panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) in its consideration of whether Mrs Vijayan has taken steps to strengthen her practice. The panel considered that there is no evidence before it of any remediation or steps taken by Mrs Vijayan to strengthen her practice. The panel considered that it has not had sight of a reflective piece detailing Mrs Vijayan's failures, or the impact of her actions on the protection of the public and the public confidence in the nursing profession. The panel was therefore of the view that there is a risk of repetition and significant risk of patient harm.

The panel therefore decided that a finding of impairment is necessary on the ground 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 the proper professional standards for members of those professions.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in a case where extensive concerns regarding a registered nurse's clinical competence were raised, and improvements were not made despite extensive support being put in place. The panel therefore also finds Mrs Vijayan's fitness to practise impaired on the ground of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Vijayan's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Vijayan's registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC.

Representations on sanction

In the Statement of Case, the NMC have submitted that a suspension order for a period of 12 months is an appropriate and proportionate sanction in this case.

The Statement of Case sets out that taking no action, or imposing a caution order would not be sufficient to protect the public, maintain standards, or maintain confidence in the NMC as the regulator.

The Statement of Case states that there is a possibility that the lack of competence in this case can be addressed through retraining. However, the NMC submitted that given the lack of evidence of remediation and steps taken to strengthen her practice, there are presently no workable conditions that can be formulated to address the concerns identified in this case, or protect the public and address the public confidence in the nursing profession and the NMC.

The Statement of Case states the following regarding a suspension order:

> *'The lack of competence in this case was perpetrated over a significant period of time and was not isolated. It is submitted that this demonstrates that the alleged lack of competence in this case may be attitudinal. It is submitted that a suspension*

order would be proportionate in all the circumstances. It is submitted that public confidence in the profession and professional standards would not be maintained if a Conditions of Practice Order were to be imposed in this case. It is submitted that temporary removal from the register would be sufficient to protect the public, and to maintain public confidence in the profession, and would be fair and proportionate in all the circumstances.'

The Statement of Case states that a striking-off order is not appropriate or proportionate in this case. It refers to Mrs Vijayan's otherwise unblemished career history, and that there is no evidence before the NMC that there has been any issues since the alleged incidents occurred.

Mrs Vijayan did not provide any submissions in relation to sanction.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Conduct which caused a colleague to suffer actual harm, and the potential to put other patients and colleagues at risk of harm
- A pattern of lack of competence over a period of 10 months
- Limited insight into failings

The panel also took into account the following mitigating features:

- Lack of knowledge of English
- Support from colleagues
- Mrs Vijayan was an international nurse who was new to the UK

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Vijayan's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Vijayan's lack of competence was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *…*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated to manage the risk identified in this case, protect the public, or engage the public interest. The panel considered the extensive support that was provided to Mrs Vijayan by the Trust including additional training, development plans, and working alongside other registered nurses. However, the panel considered that despite the extensive support, Mrs Vijayan continued to make errors that put patients and colleagues at risk of harm. The panel noted that there is no evidence before it to suggest that Mrs Vijayan is currently working as a registered nurse in the UK.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the lack of competence was not fundamentally incompatible with remaining on the register. The panel considered that a suspension order would sufficiently manage the risk identified in this case, protect the public, and maintain public confidence in the nursing profession. The panel considered that a suspension order would allow Mrs Vijayan an opportunity to remediate and take steps to strengthen her practice.

The panel did go on to consider whether a striking-off order would be proportionate. It took into account the SG which states:

‘A striking-off order can’t be used if the nurse, midwife or nursing associate’s fitness to practise is impaired due to:

- *their health,*
- *lack of competence or*
- *not having the necessary knowledge of English*

until they have been on either a suspension order or a conditions of practice order for a continuous period of two years.’

The panel considered that a striking-off order was not an available sanction in this case, and therefore could not be considered.

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

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

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of Mrs Vijayan’s lack of competence.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would likely be assisted by:

- Mrs Vijayan’s engagement with the NMC, including attendance at any future hearing
- Evidence of any further training undertaken

- A reflective piece on the impact of the facts found proved on colleagues and patients
- References and/or testimonials from colleagues in a clinical setting

This will be confirmed to Mrs Vijayan in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Vijayan's own interests until the suspension sanction takes effect.

Representations on interim order

The panel took account of the representations made by the NMC in the Statement of Case that:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.'*

Mrs Vijayan did not provide any written submissions in relation to an interim order.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts

found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to allow time for any possible appeal.

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

That concludes this determination.